DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

MONDAY, MARCH 16, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 1:35 p.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Harrison Schmitt, (chairman) presiding.

Present: Senators Schmitt, Rudman, and Burdick.

NONDEPARTMENTAL WITNESSES

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. The subcommittee will come to order. Today we begin a week of testimony from the public groups concerned with appropriations under the jurisdiction of the Labor, Health and Human Services, and Education Appropriation Subcommittee. Of necessity, the time allotted to our outside witnesses is limited in these hearings. In your testimony I hope you will give us your highest priorities for funding or nonfunding as the case may be among the major program areas.

Once we have completed the fiscal 1982 budget, hopefully by midyear, we plan a more deliberative look at the programs under the subcommittee's jurisdiction in preparation for the fiscal 1983 hearings. At that time other opportunities will exist for testimony. We will have two panels discussing Labor Department programs. The first panel consists of witnesses ranging over the entire spectrum of Labor Department programs, the second group is limited to those solely discussing employment and training programs.

Looking at the testimony witnesses have submitted in advance, it appears that most of the general labor panel will also be focusing on employment and training issues so there will be some overlap, and the subcommittee understands this. I understand the individual panelists have decided to speak independently dividing up the allotted time.

We will begin with the first panel.

Senator Burdick, did you have a statement you wanted to make?

Senator BURDICK. I don't have a statement, Mr. Chairman. Frank Lawrence, the Chairman of the Standing Rock Sioux Tribe of North and South Dakota has advised me they could not afford to send anyone to testify at this hearing today. They have prepared testimony and, on their behalf, I would like to introduce it in the record at this time.

Senator SCHMITT. Without objection that will be included in the record.

[The statement follows:]

STATEMENT OF FRANK LAWRENCE, CHAIRMAN, STANDING ROCK SIOUX TRIBE OF NORTH AND SOUTH DAKOTA

Mr. Chairman and members of the Committee, my name is Frank Lawrence and I am the Chairman of the Standing Rock Sioux Tribe of North and South Dakota. Our Reservation is located along and to the west of the Missouri River in both States and consists of over two million acres. The Indian population of the Reservation is over six thousand people. Our Reservation is a rural, agricultural area, distant from major cities and job opportunities.

Since 1974, the Public Service Employment CETA Programs have been a major--in fact, perhaps the major--employer of Indians on our Reservation. During this time, over two thousand Indian people have been employed by the CETA programs on the Reservation. They have performed a number of valuable public service functions, serving as police patrolmen and security guards in each of the geographically isolated local Indian communities on the Reservation, as conservation officers, as clerical staff for the tribal court, as orderlies, cooks and support staff and ambulance drivers for reservation health facilities, to name a few.

The unemployment rate on our Reservation at present averages over two-thirds of the available work force, and is higher seasonally in winter. If the CETA program for our Reservation is eliminated, this severe unemployment rate will be catastrophically increased.

Mr. Chairman, it is simply not true that the CETA program is ineffective, or that the jobs involved on our Reservation involve "make work" as the Administration has suggested in proposing the cutback. Let me give an example. Under the CETA program, we hire 24-hour security guards for each of the seven communities on the Reservation. This is necessary because the small tribal police force is unable completely to patrol the Reservation. Some of the Indian communities are 50 to 60 miles from the tribal headquarters at Fort Yates, North Dakota, and are extremely isolated. Only by training and specially deputizing security personnel in each community, and having them serve around-the-clock, have we been able to reduce the extremely high crime rate on our Reservation. The local security officer is able to settle disputes, take subjects into custody, and perform investigative tasks for the tribal police that would otherwise simply go undone. That is but one example of the essential features of the CETA program on our Reservation.

Unemployed CETA workers on our Reservation could not be absorbed by the private sector. At Standing Rock, as is true on many reservations, the only significant employers are in the public sector--the tribe, the federal Bureau of Indian Affairs and the federal Indian Health Service. There is simply no significant Indian private sector to employ individuals cut off by the CETA program. Nor are non-Indian employers likely to pick up slack. Ours is a rural reservation, with only a few communities with more than a hundred people. The nearest metropolitan centers of employment are at least a hundred miles away from potential Indian workers. General tax incentives or tax reductions for businesses or high income individuals will not alleviate this situation for us, because almost all Indians on our Reservation are near or below the poverty level, and few Indians have incomes high enough to pay taxes. President Reagan promised not to make cut-backs in programs that serve the truly needy. The Administration has broken its promise in this case.

Mr. Chairman, if the Indian CETA Programs are to be terminated, no savings will result to the United States. Indians of our Reservation and other reservations will simply be dependent on public assistance, without the community benefit from the CETA jobs that we now receive. And since Indians receive federal public assistance payments on our Reservation, and on most other reservations, there will not even be a shifting of the financial burden of government from the United States to individual states.

Finally, while we cannot speak about non-Indian CETA Indian programs, we can attest to the fact that the Indian CETA program is administered by tribal governments--ours and others--with a minimum of administrative costs to the United States. Only a handful of federal employees are required to administer and inspect the entire national Indian CETA program.

Mr. Chairman, we implore your assistance and that of the Committee in resisting elimination of Indian CETA programs. Thank you for the opportunity to appear before you.

OPEN RECORD

Senator SCHMITT. I would also like to say that the record is open for testimony from those witnesses who were unable to be present to testify.

The first panel will consist of Peggy Taylor, Legislative Representative for the AFL–CIO; E. Philip Riggin, Deputy Director National Legislative Commission of the American Legion; Dr. Dolores A. Davis-Wong, President of the National Caucus & Center on Black Aged; Betty Duskin, Director Research Department, National Council of Senior Citizens, Inc. You may come forward, as I call your name. Wilbur J. Cohen, a Sid W. Richardson Professor of Public Affairs, University of Texas at Austin. The prepared statements will be printed in their entirety after your oral presentation.

Welcome, and we will begin with Peggy Taylor.

LABOR PANEL

STATEMENT OF PEGGY TAYLOR, LEGISLATIVE REPRESENTATIVE, AFL–CIO

Ms. TAYLOR. I have been practicing speed talk.

Senator SCHMITT. I hope everybody realizes this is not the way the committee or the staff or any of us would like to proceed, but we're stuck with this procedure this year and we will improve on it in the future.

Ms. TAYLOR. The economic proposals of this administration represent a radical redesign of government. The budget proposals, particularly when they are considered with the substantial further out-year reductions planned, question fundamentally the legitimate role of the Federal Government in labor, health, education, and social welfare programs. The AFL–CIO does not specifically endorse any of the proposed cuts. At the same time we would never argue that programs should not be made more efficient and better targeted on those who most need them.

However, improvements and efficiency are difficult to directly legislate. They are most likely to be accomplished through the more arduous and time-consuming task of constant oversight. In my limited time I would like to concentrate on the so-called labor issues. While the balance of employment and training program emphasis may legitimately shift back and forth between the private and public sector jobs, it makes no programmatic sense to entirely eliminate one program design in one employment sector, thus limiting options to deal with a very diverse program clientele with complex job market problems. If it is private sector jobs which will now expand most rapidly, it is reasonable to increase emphasis on placement in the private sector, but no program design option should be closed off. By folding youth programs into programs for adults particularly accompanied by a major funding reduction untenable and socially divisive tradeoffs will be forced between jobs for adult heads of households and investments in future jobholders.

The maintenance of labor law administration activities is of particular importance at a time when we are attempting to rebuild our Nation's economy. An accomplishment of these activities had been relative labor peace, with systems for redress of grievances that has minimized the need for direct confrontation and strikes. If these mechanisms are effectively taken away by serious underfunding, workers will be left only with confrontation as a way of protecting the workplace and the wage standards.

For labor law enforcement and administration agencies, we recommend the January budget request for fiscal 1982 as a minimal level. These levels are approximately current service levels or slightly higher, and even they do not compensate for increased workloads and backlogs created by hiring freezes. The reductions proposed for these agencies by the Senate Labor and Human Resources Committee in their March 15 report to the budget would have a disastrous effect on labor law management, health and safety enforcement, and the labor-management relations. For example, 14,000 fewer Fair Labor Standard Act investigations would be conducted to enforce minimum wage and child labor laws; 350 fewer ARISA inspections would be made in a field where 320,000 plans cover more than $460 billion in assets for which they have only 215 field inspectors.

In Occupational Safety and Health roughly 13,000 fewer Federal inspections and 22,000 fewer State inspections could be conducted.

In MSHA where the number of inspections per mine are mandated by law, all ancillary functions would be eliminated, such as education and training.

National Labor Relations Board would end up backlogging 50 percent of the new cases brought in and hear them more than 1 year after they were originally petitioned to the Board.

Federal Mediation and Conciliation Service would have to reduce staff and close field offices, meaning a significant number of disputes needing assistance would not get it.

In closing, I think I'm close to the end of my time, I would like to address an issue that is perhaps as significant as the actual funding cuts. We are very concerned about the enormous usurpation of authority and discretion of the authorizing and appropriating committees which is inherent in a broadly encompassing reconciliation process being contemplated this year.

If the budget committees can direct authorizing committees to lower authorization ceilings, what discretionary role is left to the appropriation committee? If the budget committees can dictate how much each appropriation subcommittee can spend, what has become of the discretion of the full Appropriations Committee.

If education programs, social service programs, health programs, and manpower programs can be rolled into block grants, what oversight can be conducted by this committee? The reach of reconciliation has the potential to absolutely minimize the traditional deliberative role of congressional committees such as Appropriations, and because of budgetary procedural protections to stifle full and open debate of these issues on the floor of the Congress.

We realize this is outside the purview of these hearings but raise it anyway from a sense of the urgency of this situation. Thank you very much.

Senator SCHMITT. Philip Riggin, deputy director, National Legislative Commission, American Legion.

STATEMENT OF E. PHILIP RIGGIN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. RIGGIN. Thank you, Mr. Chairman. It's indeed a privilege for me to present the views of the American Legion today on the Department of Labor budget for fiscal year 1982. Unfortunately due to the nonavailability of precise budget recommendations from the administration we will be hampered in our efforts today to present specific arguments on funding levels.

Mr. Chairman, the American Legion is greatly concerned over rumored budget cuts which would seriously affect veterans employment programs. In fact, we believe if Congress approves such cuts there would be little or no recovery of veterans' programs to any degree of effectiveness at any point in the future.

There has already, in our opinion, been too great a sacrifice made by veterans, especially Vietnam era veterans, and now, in our opinion, is not the time to curtail veterans' employment programs. It's a time, however, for this Nation to come to terms with very substantial and very real problems.

One of those problems is that unemployment rates for disabled veterans are astronomical and they border on becoming a national embarrassment.

Mr. Chairman, we are particularly disappointed by contemplated budget cuts in veterans' employment activities at this time, because such cuts would come on the heels of what we consider to be gains made during the 96th Congress. For example, during the 96th Congress, legislation was enacted to improve the status of veterans employment within the Department of Labor. This legislation, Public Law 96-466, created a full Assistant Secretary of Labor for Veterans Employment. It established the much-needed clerical positions for State directors of veterans employment and it transformed the highly successful disabled veterans outreach program to permanent status. With the enactment of this measure Congress clearly registered its support for veterans employment and we appeal to this subcommittee to approve appropriations for full implementation of Public Law 96–466.

As mentioned earlier, Mr. Chairman, disabled veterans, especially Vietnam era veterans, have an astronomical rate of unemployment. In fact, it's probably higher than official records show since many disabled Vietnam era veterans have simply dropped out of society and are no longer reported in labor market statistics.

Yet there is, in our opinion, a successful program which has been highly responsive to these special needs, and that program is the disabled veterans outreach program. This outreach effort is responsible for thousands of veterans being contacted, counseled, and given proper guidance, thus restoring to these people a sense of dignity and self-esteem. According to current Veterans' Administration estimates of the Nation's veteran population, a nationwide staffing of 2,000 would be needed to fully implement the disabled veterans outreach program. Presently there are about 1,400 staff people around the country in this program. This, of course, leaves a shortfall of some 600 positions. This shortfall becomes particularly critical when one considered recent information describing administration desire to fund the disabled veterans outreach program out of grants to States, one of the main sources for funding for State employment activities.

We are concerned about this for one reason, and that is displacement of State employment personnel to accommodate disabled veterans outreach personnel would, in our opinion, create a friction at local employment offices which would seriously reduce the effectiveness of the disabled veterans outreach effort.

Mr. Chairman, these are highlights of our prepared statement. We do hope the subcommittee will take these matters into consideration when it makes its final decision on the appropriations for fiscal year 1982.

Senator SCHMITT. You can be sure that we will. We appreciate that. The next witness is Dr. Dolores A. Davis-Wong, president, National Caucus and Center on Black Aged.

STATEMENT OF DR. DOLORES A. DAVIS-WONG, PRESIDENT, THE NATIONAL CAUCUS AND CENTER ON BLACK AGED

Dr. DAVIS-WONG. Mr. Chairman, thank you. It's a pleasure to testify here today on behalf of the National Caucus and Center on Black Aged.

I would like to say at the onset that we, the National Caucus serves as an advocate of the truly poorest segment of this Nation's population, the elderly black people. I know the mood of Congress is to cut budgets. However, not every single social welfare program has to be cut and programs should be—the cut should be well timed and well conceived funding increases in some programs, particularly those where elderly black Americans and all older black Americans, elderly Americans, of the title V work program have been doing an outstanding job.

The reason that we suggest that we're going to ask for a very minimal increase in the title V program is because of the increase in poverty in the population over the last year—500,000 older persons in 1979 were below the poverty level. It's expected the poverty level will increase and the title V older workers service program provides an opportunity for older people with very, very meager incomes, low incomes, to supplement their income and they are providing opportunities in the community. The work service and hospitals and other programs.

So NCBA is suggesting and recommending that we have an increase at the current time. The community service and employment program be increased from $277.1 to $290 million. That's only a 12-percent increase. We're making this recommendation because poverty has risen so substantially for older persons. A more substantial increase would clearly be justified, and the money will be well spent. However, the National Caucus and Center on Black Aged is opposing this increase because of the tight budgetary constraints.

Title V has been an extraordinary program over the years. It has been well administered, free of fraud, free of abuse, and it helps older people continue to be productive in our society. Approximately $9 out of every $10 title V pay for worker's wages, fringe benefits and related services. NCBA believes the proposed increase is also needed because the administration's estimate of the costs for title V is $5,111.

However, the real cost is somewhere between $5,300 and $5,400 because of increased operating expenses such as transportation costs, social security payroll taxes, and other related expenses. The administration's average enrollee costs, though, has not increased to take into account these higher expenditures.

NCBA also recommends that another program under the Administration on Aging, title IV training and discretionary projects under the Older Americans Act be continued at the fiscal 1981 level—$14 million for training and $15 million for demonstration. Congress approved an 18-percent cut for training in fiscal 1981. Any further cut would be harmful to the program and would be counterproductive.

Right now a critical shortage of adequately trained personnel exists in the field of aging. In fact, it is one of the most critical problems in the field of geriotology today. In recent years Congress has increased funding significantly to provide more services to enable more workers to live independently in their communities.

NCBA does not believe that we should cut back training funds when a critical need exists to prepare more people to deliver vitally needed service for the elderly. We also feel continuing title IV discretionary programs at the 1981 funding level of $15 million, title IV demonstrations programs would be especially during a period of austerity. If funding for basic services will be essentially stabilized or reduced, demonstration programs which can be useful to develop cost effective models for service providers to replicate delivery services to older persons.

In addition, title IV demonstrations can be an important tool to respond to a growing service and economic problems for older Americans and other minorities. Ideally speaking, this program should be expanded because of its high potential payoff in improving service delivery and responding to needs of older persons. We urge the subcommittee to adopt these modest proposals to assure that we continue to make progress in responding to the current problems of older Americans.

We believe these recommendations are realistic. They represent a cost-effective way to come to grips with the modern serious problems affecting older Americans. We realize our support for these measures are modest and call upon the subcommittee to approve them.

Thank you very much.

Senator SCHMITT. Thank you. Our next witness is Betty Diskin, director of research, Department of the National Council of Senior Citizens, Inc. If it would help, I would be happy to give you a 1-minute knock on the gavel. OK? One minute left.

STATEMENT OF BETTY DISKIN, DIRECTOR, RESEARCH DEPARTMENT, NATIONAL COUNCIL OF SENIOR CITIZENS, INC.

Ms. DISKIN. Yes, I will try to accommodate the committee by being extremely brief.

Since the topic I've come here to discuss is at least, in part, similar to what Dr. Davis-Wong has already discussed, and that's title V of the Older Americans Act, the senior community service employment program. I believe it comes close to being an ideal manpower program. It serves those who otherwise would not have good prospects in the labor market, that's the elderly poor, 55 and older. It does not duplicate or substitute for jobs already out there; it creates new jobs in community service work that's not otherwise provided to the community at large; and it substitutes the prevailing wage for the function that is performed for what would otherwise be public assistance to these people.

So, it performs a community service, it performs an income maintenance function in the best possible way, and it also serves the interest of society at large by bringing the elderly back into the mainstream of life. It is terribly important to them psychologically, emotionally, and in every other way. I ask that my tesimony be submitted for the record, and I as merely as far as the appropriations are concerned that you at least maintain all the jobs that are currently available to the elderly poor and that you be as generous as you find it in your heart to be for those who are waiting in line for the opportunities that this program offers them.

I might just add one comment, and that is I agree with Miss Taylor in regard to her concerns voiced over the reconciliation process. I am deeply concerned that the public hearing that has heretofore been available on all substantive issues will be denied the public and the committees in the House and the Senate.

Senator SCHMITT. Thank you very much. I notice similar concerns elsewhere. Our final witness in this panel is Wilbur J. Cohen, Sid W. Richardson professor of public affairs, University of Texas, and former Secretary of HEW, right?

Mr. COHEN. Right.

Senator SCHMITT. Welcome, sir.

STATEMENT OF WILBUR J. COHEN, SID W. RICHARDSON, PROFESSOR OF PUBLIC AFFAIRS, UNIVERSITY OF TEXAS AT AUSTIN

Mr. COHEN. Thank you, sir. I originally made the appointment to testify before this committee because I thought as a former secretary I might be of some assistance to a new chairman of this committee in looking at the whole problem of HEW, now HHS, but since I have been assigned to come in the beginning, I have decided, after talking with your staff director, to submit to the committee these two reports which I have spent 3 years working on in analyzing the administration of both the unemployment insurance employment service and social security program. I was appointed chairman of one of the committees by the President of the United States, and the other by the Speaker of the House.

There are very substantial chapters in here which I think your staff would well be able to get information out of, about how to allocate some of the administrative funds to reduce fraud and abuse, to increase the audits to deal with the extensive overpayments that exist, and to provide better service to people, including, I think you will find in here, have the employment services that will be able to find jobs for people because the staff has been so limited over the past few years. These are documented in these two reports which I think the staff and you, if you can have them briefed, you will find very useful information because this is a result of 3 years of work of two independent commissions.

I would only like to point out two particular points. One is that the administrative costs above the unemployment insurance system and 97 percent of the employment service system and all of the social security program do not come out of general revenues. They are all paid out of the payroll taxes which employers pay for unemployment insurance or which employees and employers pay for social security. I think, therefore, when you come to appraise the efficiency of the program, and the allocation of appropriations which you make for them, you should realize that none of those are coming out of the general revenues, and that the people who pay those taxes assume a high degree of efficiency and operation and cost efficiency of the program, which ought to be taken into account.

The second point is, sir, that these two commissions have recommended that both of these insurance programs be taken out of the Federal unified budget. While I recognize that that is not a matter solely within the jurisdiction of your committee, it would have a very substantial impact in reducing the size of the Federal budget because these two programs are contributory programs which were originally thought to be financed in a separate insurance way in which the Federal Government was acting as a fiduciary in its insurance capacity and not in terms of general revenue. Since 1968–69 they have been engulfed both for surplus and deficit into the Federal unified budget and I think this has alarmed a lot of people because if you can collect more money it helps the budget situation. If you cut the benefits or the administration, it reduces the deficit.

But these are not the real policy matters that should be determined by this committee or Congress. It should be the merits of the insurance program itself because nobody would justify payroll taxes to be a basis for financing general revenues of the Government. So I hope very much, though, that you will give consideration to these reports.

Both of them have a number of substantive recommendations in them that go to the substantive committees, of course, but insofar as they deal with administration, I believe you'll find them valuable.

I'd like to submit this short statement for the record which are my views on the impact of the budgetary changes that have been recommended in social security which I vigorously opposed because I believe that it is not sound to cut social security for budgetary purposes when the financing of the program is out of a contributory insurance program financed by payroll taxes. I would like that statement to be in the record.

Senator SCHMITT. Your statement will be included in the record. Your reports will be retained in the subcommittee files. They will be very useful to us.

Thank you all very much. I wish we had time for questions, but we do not.

[The statements follow:]

Statement of Peggy Taylor

Over many decades the constituency of your Committee - workers, the young, the very old, the disadvantaged, the economically dislocated, and the handicapped - have turned to their government system for the justice that was not provided to them by the market system. And the government responded. Programs were proposed, carefully considered, enacted by the Congress, deliberately funded, checked and reviewed - as is provided for under this nation's system of governance.

As a result, social progress was exacted from an economic system that refused to grant it. It has been a slow, painful process, but a necessary one. When the more limited self-interest of a local government or a local political system ignored national interest, the Federal government assumed a legitimate role of provider or intervenor.

The proposals that this Administration has placed before us in the past month - particularly when they are considered together with the very substantial further reductions that are planned for future years - question fundamentally the legitimate role of the Federal government in labor, health, education and welfare programs. These proposals appear to have been prescribed by a rather purist philosophy of economics and government which has been diluted only by political considerations of the most overriding nature. The notion that there is no legitimate role for federal government is as impractical as the idea on the other end of the spectrum that the state should be totally controlling and all services should be run by the government.

Our system has carefully balanced free market capitalism and government assistance. The dynamics of physics which predict the path of a pendulum suggest that if this country is pulled as dramatically back as recommended into a free market capitalism mode of operation that that motion will set in motion an equally strong countermotion in the direction of government intervention.

To go back to the more immediate questions before this Subcommittee, we have a deep and continuing interest in education, health and welfare, and do not specifically endorse any of the proposed cuts. In fact, we are participants in a coalition of over

160 organizations which is opposed to the approach taken by the Administration to counter real economic issues with attacks on these programs.

At the same time, we would never argue that programs should not be made more efficient and programs better targeted to those who most need them. There is certainly no greater enemy to a program's survival than poor administration. However, improvements in efficiency are difficult to directly legislate. They are most likely to be accomplished through the more arduous and time-consuming task of constant oversight. Your committee, because of the annual appropriations review for all programs, has provided that oversight on a more regular basis than most other Congressional committees. Yet, the demands on the time of Congress have always resulted in legislative initiative taking precedence over oversight of existing laws.

Others who will testify before you will bring you information about the grave human consequence of the Administration's proposals in education and social welfare. In my limited time, I would like to concentrate on the so-called "labor" issues, but it is important to keep in mind the interrelation of social programs.

While we are gravely concerned about the cutbacks being proposed for unemployment insurance and trade adjustment assistance, since those are not discretionary appropriations, I will not take your time now with our arguments on the merits of those proposals. We would be glad to provide the Committee with copies of our position on those issues.

While the balance of employment and training program emphasis may legitimately shift back and forth between private and public sector jobs, it makes no programmatic sense to entirely eliminate one program design and efforts in one employment sector, thus limiting options for dealing with a very diverse program clientele with complex job market problems. When the public service jobs program was expanded rapidly in 1977, the approach was justified not only because those jobs could be created relatively rapidly but also because public sector employment was then the fastest growing employment sector of the economy, representing a significant potential market for permanent placement. If it is private sector jobs which will now expand most rapidly, it is certainly reasonable to increase emphasis on placement in the private sector. But no program design option should be closed off.

The problem of youth unemployment has never been a partisan issue. Youth training programs represent an investment in our future labor force. But by folding youth programs into the programs for adults, particularly accompanied by a major funding reduction, untenable and socially diversive trade-offs will be forced between jobs for adult heads of households and investments in future job holders.

The maintenance of labor law administration activities has particular importance in a time when we are trying to rebuild our nation's economy. An objective and an accomplishment of these activities has been relative labor peace, with systems for redress of grievances which minimize the need for direct confrontation and strikes. If these mechanisms are effectively taken away by serious underfunding, workers may be left with only confrontation as a way of protecting their workplace and wage standards.

For the labor law enforcement and administration agencies within the Department of Labor--the Employment Standards Administration, the Labor-Management Services Administration, the Occupational Safety and Health Administration, and the Mine Safety and Health Administration--and labor-related independent agencies--the National Labor Relations Board, the Federal Mediation and Conciliation Service, the National Mediation Board, the Occupational Safety and Health Review Commission, the Mine Safety and Health Review Commission and the Equal Employment Opportunity Commission--we recommend the January budget request for FY 1982 as a minimal level. Even the January budget, which is approximately at the FY 1982 current services level or slightly higher, did not compensate for increased workloads, backlogs created by hiring freezes, or additional activities of some of these agencies.

The reductions proposed for these agencies by the Senate Committee on Labor and Human Resources in their March 15 report to the Senate Budget Committee will have a disastrous effect on labor law enforcement, safety and health protection and labor-management relations in this nation. Massive backlogs of election petitions, unsafe worksites ignored, labor-management conciliation unachieved, and wage-hour and pension abuses left untouched can only tear at the stability of labor relations in America.

We have very briefly detailed below some of the impact which we calculate will result from cutting these agencies' budgets 20 percent below the FY 1981 funding level.

Employment Standards Administration

A 20 percent cut from 1981 activity levels would mean 14,000 fewer Fair Labor Standard Act investigations, 800 fewer Farm Labor Contract Registration Act investigations, 800 fewer federal contract labor standards investigations, and 1,300 fewer federal contract compliance investigations. Processing of wage/hour violation complaints would take a significantly larger portion of agency time, severely cutting back on the agency's self-initiated investigations of employers or industries with a pattern of wage discrimination.

Labor-Management Services Administration

The Pension and Welfare Benefits Administration would conduct 350 fewer ERISA investigations into pension plan administration. At present there are only 215 field investigators to cover 320,000 plans which in 1975 covered $460 billion in pension assets.

Occupational Safety and Health Administration

A 20 percent cut from 1981 activity levels in enforcement would mean 12,600 fewer Federal inspections and 22,600 fewer State inspections. Additionally, severe cutbacks would be made in employer consultation, employee education, standard setting,

Mine Safety and Health Administration

Almost all MSHA inspections are made in compliance with statutory mandates to inspect surface mines twice a year, coal mines four times a year, gassy mines every 10 or 15 days and to respond to accidents and complaints. Therefore, a 20 percent reduction in the MSHA budget will result in very severe reductions in all ancillary services, such as consultation and training and could impinge on their ability to meet mandatory inspection schedules.

National Labor Relations Board

For the first time in its history, the National Labor Relations Board has begun building up a serious backlog of cases as a consequence of the Carter administration hiring freezes. The 20 percent cutback would triple the current 7,000 case backlog to 25,000. The NLRB is a case-processing agency and has no control over the number of cases sent for consideration. At present approximately 50,000 cases are handled a year. The multi-year effect of compounding the 25,000 case backlog would be to grind the agency to a virtual halt.

Federal Mediation and Conciliation Service

FMCS mediates labor disputes when the parties involved request their help. It is not an enforcement agency. In the past four years FMCS staff have been reduced by 13 percent, eliminating all "fat" and cutting administrative expenses to an absolute minimum. The 20 percent reduction would literally mean that a significant number of disputes needing mediation assistance would not get it. The cuts would mean reductions in force and closing field offices.

National Mediation Board

The NMB, by law, is heavily involved in rail and air labor-management relations. Under legislation governing these industries, the NMB mediates, conciliates, arbitrates and runs representational elections. A 20 percent reduction would have a geometric impact on these activities and cause severe work slowdowns and backlogs that could seriously effect national commerce.

In closing I would like to address an issue which this year is of perhaps as great significance as the actual funding cuts proposed.

While we realize the Senate Majority's commitment to move the Reagan economic package through Congress with great speed, we are concerned with the enormous usurpation of authority and discretion of the authorizing and appropriating committees which is inherent in a broadly encompassing reconciliation process.

If the budget committee can direct authorizing committees to lower authorization ceilings, what discretionary role is left to appropriations? If the budget committee can dictate how much each appropriations subcommittee can appropriate, what has become of the discretion of the full appropriations committee? If most education, social service and manpower training programs are rolled into block grants, what sort of oversight can be exercised through appropriations?

The reach of reconciliation has the potential to absolutely minimize the traditional deliberative role of congressional committees such as appropriations, and to stifle full and open debate of the full Congress on bills as they reach the floor. We realize that this is outside the purview of these hearings, but raise it anyway from a sense of the urgency of the situation.

STATEMENT OF E. PHILIP RIGGIN

The American Legion has long supported full funding of the Department of Labor in order that it may operate and carry out an efficient and effective job counseling, job placement and training program for veterans and other necessary employment programs designed to enhance the economic opportunities of veterans.

It is therefore a privilege to submit the views of The American Legion on the proposed budget of the Department of Labor for fiscal year 1982.

Current resolutions requesting support full funding for veterans preference and activities were adopted at our 1980 Annual National Convention and National Executive Committee meeting and along with other pertinent correspondence are attached hereto with the request that they be made part of the record.

Mr. Chairman, at this critical time in our nation's economic well-being, The American Legion is greatly concerned that proposed budget cuts of the Department of Labor will seriously affect veterans' programs. So concerned are we that it is the general feeling that should veterans' programs be gravely affected, there would be little or no recovery of veterans' programs to any measure of effectiveness. We of the Legion, beside being veterans, are also citizens and taxpayers and thus also support measures to bring our economy into line. But there is not one among us who would agree that to do so means that veterans' employment programs must be sacrificed.

There has been too great a sacrifice by veterans already, especially Vietnam Era Veterans; now is not the time to curtail veterans' employment programs. It is a time for this nation to come to terms with substantial and very real problems. A recent Lou Harris study revealed that among Vietnam Era Veterans jobs were their first priority and that for the most part, people are not offended at veterans, especially Vietnam Era Veterans, receiving priority employment treatment. But the sad fact is that Vietnam Era Veterans have not been given any treatment, let alone priority treatment. Recent figures on veterans' unemployment indicate that younger veterans have a much higher unemployment rate than non-veterans in the same age bracket. Moreover, unemployment rates for disabled veterans are astronomical and border on becoming a national embarrassment.

Mr. Chairman, the situation would indeed deteriorate rapidly should veterans' programs be further cut. The Veterans Employment Service is today operating under a terrific strain. Presently there exist approximately fifteen (15) vacant field positions, with three (3) potential vacant positions. Some of these positions have been vacant for as long as eighteen (18) months; and now with the hiring freeze in effect, are likely to go unfilled for some time. Veterans Employment Service field staffs are the key to an effective veterans' employment program; they are the dedicated individuals who must ensure that the states are addressing the needs of unemployed veterans. The responsibility falls on the field staff to actually travel to various locations within their jurisdiction and make on-site inspection of veterans' programs. Thus, travel plays a crucial role in their job description; and to reduce travel funds to the field would relegate them to a position of uselessness and inefficiency. The states then would totally disregard veterans' employment programs resulting in even higher rates of veterans' unemployment. It is even difficult now to ensure full state compliance. Recent figures indicate that between ten (10) and twelve (12) states are out of compliance and Veterans Employment Service is faced with the task of bringing those states into minimum acceptance levels.

The American Legion was very pleased when former President Carter signed into law PL 96-466 in October of 1980, for that law not only satisfied many Legion mandates, it ended a long and arduous effort to see that veterans' employment programs within the Department of Labor are given their proper due; but the battle in many respects is just beginning. PL 96-466 as you know, among other things, created within the Veterans Employment Service, a full Assistant Secretary for Veterans Employment; established the much needed clerical positions for the State Directors for Veterans Employment Service; and transformed the highly successful Disabled Veterans Outreach Program to a permanent statutory program. One could conclude that veterans' employment programs were now fully covered; but that would be an erroneous conclusion as all are needed; that legislation failed to make any appropriations available to implement the clerical and DVOPs. Both must be funded from a separate appropriations measures.

A short time ago, The American Legion made a survey through its departments as to the importance of clerical assistance to the State Directors of Veterans Employment. The overwhelming response was that SDVE in the Federal system would not be able to function without the assured clerial assistance of qualified secretaries within the Federal personnel system. One state commander said, "It would be next to impossible for the State Veterans Employment Representatives to adequately perform his duties ..." without clerical assistance. Another Legion official pointed out that the present secretary in the office of the SDVEs not only handled all correspondence and other office work for a director and assistant director located in that city, but also for an assistant director located 375 miles away. Moreover, according to the recent Veterans Employment Service Operations Manual, "A major key to the success of the operation of the SDVEs office is the efficient functioning of the secretary."

As mentioned earlier, disabled veterans, especially Vietnam Era Veterans, have an astronomical rate of unemployment. It is, without exaggeration, probably higher, for many disabled Vietnam Era Veterans have simply dropped out of society; cynical of the programs designed to aid them. Nonetheless, there is one successful program which is highly responsive to their special needs; that is, the Disabled Veterans Outreach Program. This program is responsible for thousands of disabled veterans being contacted, counseled and given proper guidance; thus restoring to the veteran a sense of dignity and self-esteem. The American Legion is proud to be associated with this program and supports the efforts of the Department of Maine which for years has run the Disabled Veterans Outreach Program for the entire state. But success in one state does not mean success in others. However, with the enactment of PL 96-466, the Disabled Veterans Outreach Program will be given the opportunity to truly prove its worth on a national scale. But again, as with the clerical positions, the above legislation made no provision for funds. Based on current Veterans Administration estimates of veterans population, a nationwide staffing level of 2,000 is needed to fully implement the program. Presently, there are only approximately 1,400

Disabled Veterans Outreach Program staffers; thus, the Department of Labor is faced with a short-fall of 600 positions, a significant amount indeed. Once again the Department has the alternative to seek separate appropriations or look to existing programs.

One program area that could not be reduced any is the State Employment Service. Since 1966 they have been under a mandatory personnel ceiling of 30,000; and yet the labor force has increased more than 25 percent since that time, resulting in increased responsibility for special emphasis programs, such as veterans. This 30,000 figure is entirely inadequate and unrealistic, and The American Legion supports increased funding for the State employment service. However, this may not be, as there is some talk that funding for the Disabled Veterans Outreach Program is to be taken from Grants to States, one of the main sources of State employment service funding. Should this happen, it would be a disaster; not only for them, but for the Disabled Veterans Outreach Program and other veterans' employment programs. Separate and exclusive funding must be had for all programs.

Mr. Chairman, one last comment on the clerical and Disabled Veterans Outreach Program staffing position. Under PL 96-466 which created these positions, and 5 U.S.C. 2002 regarding the Veterans Employment Service field positions, the Secretary of Labor is mandated to make all such appointments. However, due to the government wide hiring freeze it is felt that no appointment will be forthcoming, thus frustrating the intent of Congress. Importantly, what is of conflict here is the question over which takes precedence, a statute or Presidential Executive Order. It is well settled in American jurisprudence that the Constitution is the supreme law of the land, followed by statutes, with Presidential Executive Orders, Proclamations and other pronouncements following. This fact is underscored in McCann Mfr. Co., Inc. V. United States ET AL (98 F. Supp. 225) and Warner Construction Co. V. Krug, Secretary of the Interior (80 F. Supp. 81) wherein the courts, without lengthy debate or deliberation, stated that should a statute and Presidential Executive Order be in conflict, the former prevails. Thus, regarding the vacant Veterans Employment Service field positions; the clerical positions; and the Disabled Veterans Outreach Program;

and notwithstanding the Presidential Executive Order imposing a hiring freeze, the Secretary of Labor is mandated to fill these positions.

Mr. Chairman, veterans' employment programs are at a critical juncture. They balance on the edge of total disaster should full funds not be provided. There could be no, and will be, no recovery for veterans' employment programs unless the Department receives full funding; veterans of this nation deserve no less.

Thank you for allowing The American Legion to express its views.

NATIONAL EXECUTIVE COMMITTEE
OF THE AMERICAN LEGION
INDIANAPOLIS, INDIANA, OCTOBER 15-16, 1980

RESOLUTION NO. : 34

COMMITTEE : ECONOMICS

SUBJECT : SWIFT AND EFFECTIVE IMPLEMENTATION OF 1980 VETERANS EMPLOYMENT ASSISTANCE AMENDMENTS

WHEREAS, Title 38, United States Code, has recently been amended by Congress to improve employment services to veterans by, among other things, creating an Assistant Secretary of Veterans Employment to advise the Secretary of Labor and have other responsibilities; and by converting the present administratively established and separately funded Disabled Veterans Outreach Program (DVOP) to an ongoing Department of Labor/State operated veterans employment and training outreach program; and

WHEREAS, The unemployment rate for veterans in the 25-29 year age group, which comprises 85 percent of all Vietnam era veterans, was 7.1 percent in July 1980, compared to the 6.4 percent rate for nonveterans in the same age group, and more than twice the rate for these Vietnam era veterans in July 1979, thus necessitating effective implementation of these new provisions; and

WHEREAS, While Congress provided that DVOP shall continue, no provision was made for the funds necessary to continue this program; and

WHEREAS, The Assistant Secretary of Veterans Employment should be a veteran in order to fulfill his responsibility and obligation to effectively implement the veterans employment program within the Department of Labor; now therefore be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on October 15-16, 1980, that The American Legion urge the President to immediately appoint an Assistant Secretary of Labor for Veterans Employment as mandated by Congress, and that this appointee be a veteran in order that the existing and newly mandated responsibilities of the Department of Labor for promoting full employment of veterans be effectively carried out; and be it further

RESOLVED, That the Secretary of Labor be urged to immediately make adequate funds available for effectively continuing the Disabled Veterans Outreach Program with full staffing and responsibility as mandated by Congress.

SIXTY-SECOND ANNUAL NATIONAL CONVENTION
OF
THE AMERICAN LEGION
AUGUST 19-21, 1980
BOSTON, MASSACHUSETTS

RESOLUTION NO.: 80

COMMITTEE : ECONOMICS

SUBJECT : SEEK INCREASE IN STAFF FOR STATE EMPLOYMENT OFFICES

WHEREAS, The public employment service has been in existence since 1933 providing free job finding assistance to unemployed persons; and

WHEREAS, One of the primary functions of the employment service is to provide veterans with an effective priority service, with each full functioning office having a veterans employment representative and one or more Disabled Veterans Outreach Program staff; and

WHEREAS, The employment service budget remains at a substandard level for the tenth consecutive year in spite of a 29 percent increase in the size of the labor market and a substantial increase in the use of the employment service by employers and unemployed persons during the past several years; and

WHEREAS, This huge increase in services requires additional positions throughout the United States in the employment services to maintain and improve employment services for veterans and all other applicants; now therefore be it

RESOLVED, By The American Legion in National Convention assembled in Boston, Massachusetts, August 19, 20, 21, 1980, that The American Legion request that the Congress and the Department of Labor support an increase of positions in the State employment services to a number commensurate with the increase in the labor force so that an effective employment service, including employment services to veterans, can be maintained.

RESOLUTION NO. : 430

COMMITTEE : ECONOMICS

SUBJECT : SEEKS FUNDING FOR INCREASED EMPLOYMENT SERVICES FOR DISABLED AND OLDER VETERANS

WHEREAS, The American Legion has always been deeply concerned with the specialized needs of the disabled and older veteran, as evidenced by long standing employer awards and other efforts; and

WHEREAS, The advancing age of World War II and Korean veterans is creating serious employment problems for these veterans, especially during the current recession and lay-offs, and disabled veterans nearly always encounter employment difficulties; and

WHEREAS, The responsibility for providing specialized services to meet the employment problems of disabled veterans and older veterans has been given to the U.S. Department of Labor, its Veterans Employment Services, and the State employment agencies, now therefore be it

RESOLVED, By The American Legion in National Convention assembled in Boston, Massachusetts, August 19, 20, 21, 1980, that The American Legion urge the U.S. Department of Labor, its Employment and Training Administration, the Veterans Employment Service, and the State employment agencies to increase and intensify and make more effective employment services to disabled and older veterans; and be it further

RESOLVED, That The American Legion request Congress to provide adequate funds so that the designated Federal and State agencies can fully comply with their responsibilities to serve the specialized employment needs of disabled and older veterans.

RESOLUTION NO. : 505

COMMITTEE : ECONOMICS

SUBJECT : FULL FUNDING FOR THE VETERANS EMPLOYMENT SERVICE

WHEREAS, Chapters 41 and 42, title 38, United States Code, provide for an effective job placement, counseling and training programs for veterans, and provide, in Chapter 41, that the Secretary of Labor supply necessary funds for this purpose; and

WHEREAS, The U.S. Department of Labor has not fully responded with meaningful and productive efforts to provide for maximum employment and training opportunities for veterans; and

WHEREAS, The U.S. Department of Labor continues to inadequately fund Federal and State agencies, namely, the Veterans Employment Service of the U.S. Department of Labor and the State employment service agencies; and

WHEREAS, As a result of noncompliance with Federal statutes, the U.S. Department of Labor is compounding the problem of unemployment of veterans, especially unemployment problems of disabled and Vietnam era veterans, which continue to remain at high and unacceptable levels; now therefore be it

RESOLVED, By The American Legion in National Convention assembled in Boston, Massachusetts, August 19, 20, 21, 1980, that The American Legion request that the Secretary of Labor shall submit to Congress a line-item budget for the operation of the Veterans Employment Service; and require fiscal accountability to ensure that funds appropriated for the Veterans Employment Service and for veterans employment services in the State Employment agencies are, in fact, used for such veterans employment services.

RESOLUTION NO. : 736

COMMITTEE : ECONOMICS

SUBJECT : OPPOSE ANY CHANGES IN EMPLOYMENT SERVICES TO VETERANS HAVING ADVERSE EFFECT ON VETERANS

WHEREAS, The Congress of the United States, in the passage of the Wagner-Peyser Act of 1922, provided for the creation of the United States Employment Service and the Veterans Employment Service; and

WHEREAS, Chapter 41, title 38, U.S. Code, provides that the Veterans Employment Service, within the Department of Labor, shall have an effective job placement program for veterans, and that the Secretary of Labor shall determine that adequate funds are made available for the Veterans Employment Service program at the national, regional and state levels; and

WHEREAS, Numerous proposals have been submitted to the Congress for consideration to amend the Wagner-Peyser Act; now therefore be it

RESOLVED, By The American Legion in National Convention assembled in Boston, Massachusetts, August 19, 20, 21, 1980, that The American Legion oppose any changes in the present employment services administered by the Department of Labor and established by the Wagner-Peyser Act that would have an adverse effect on programs of services to veterans.

February 19, 1981

Honorable Raymond J. Donovan
Secretary of Labor
Washington, D.C. 20210

Dear Secretary Donovan:

Thank you for taking the time from your busy schedule to meet with Frank Kelly, myself, and other representatives of the major service organizations. I wish also to thank you for your candor and honesty in discussing Department of Labor problems and I extend to you the assistance of The American Legion.

Our letter of February 9, 1981 pointed out the major concerns of the Legion as they relate to the Veterans Employment Service. However, regarding our discussion, I would like to reiterate that as far as the Assistant Secretary for Veterans Employment is concerned, the Legion is mandated to remain neutral and not endorse any candidate. Nonetheless, we feel that the individual should be a veteran, have a successful "track record" in the area of veterans' employment, and be able to assume the position with little or no difficulty.

One area that was not touched upon, but is of significant concern to us is funding for the Disabled Veterans Outreach Program. As you may be aware, this program is highly successful and provides a meaningful service to veterans. In October of 1980, ~~this~~program was made statutory under PL 96-466, allowing for approximately 2,000 positions, however, appropriations for this program were not included.

It is imperative, therefore, that full funding be provided for this program, but not at the cost of any other program designed in whole or in part to assist veterans. There has been some discussion that funding should come from Title III or Grants to States. Funding from the latter source would be detrimental to the U.S. Job Service, which has been under a 30,000 personnel ceiling since 1966, and thus could not sustain any measure of efficiency and responsiveness should their funding be reduced. Moreover, in the end, no program would benefit and all would be severely hurt.

We are grateful for your statements that you will seek our counsel on any Assistant Secretary for Veterans Employment nomination and that Dr. Wyant will remain in place as Deputy Assistant Secretary for Veterans Employment until such time as an Assistant Secretary for Veterans Employment is nominated and confirmed. We are also encouraged that you wish to maintain an open door policy and plan to reinstitute the Secretary's Veterans Council.

Thank you for allowing me the time to express our views.

Sincerely yours,
JAMES G. BOURIE
Director for Economics

February 25, 1981

Mr. T. Timothy Ryan
Solicitor of Labor
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Dear Mr. Ryan:

On behalf of The American Legion, I extend to you our congratulations on being named as Solicitor of Labor, and that I look forward to working with you on the Secretary's Veterans Council to address the serious problem of veterans' unemployment.

Undoubtedly, you are aware that President Reagan has imposed a government-wide hiring freeze retroactive to November 4, 1980. The merits of such a retroactive hiring order are not at issue here, but what is of issue is an obvious and serious conflict between a Presidential Executive Order and a federal statute.

Title 38, Section 2003, United States Code Annotated, provides that "the Secretary of Labor shall assign to each State a representative of the Veterans Employment Service to serve as the veterans' employment representative, and shall further assign to each State one assistant veterans employment representative for each 250,000 veterans and eligible persons of the State veterans population..." Presently, within the Veterans Employment Service field structure there exist approximately fifteen (15) vacant positions and three (3) potential vacant positions, with some of these positions being vacant for as long as twelve months.

But these positions, however, are not the only ones the Secretary is mandated to fill. PL 96-466, enacted in October 1980, amended 38 U.S.C.A., Chapter 41, Section 2003, to provide that the Secretary "...shall assign full time clerical support to each such [Veterans Employment Service] representative." PL 96-466, at 38 U.S.C.A., 2003A, established the Disabled Veterans Outreach Program, with approximately a 2,000 nation-wide staffing level, vesting in the Secretary all such appointment authority.

It is our contention that, in the event of a conflict between a statute and a Presidential Executive Order, the statute prevails. It is well settled in American jurisprudence that the Constitution is the supreme law, followed by statutes, and that, in the event of a conflict between a statute and a Presidential Executive Order, the former shall control.

This point is underscored in the McGann Manufacturing Company, Inc., et al v. United States et al (98 F. Supp. 225), wherein the District Court stated that "...[i]t is fundamental that the provisions of the Executive Order are not controlling insofar as they may be inconsistent with the Act itself," and that "...[I]t is elementary law that executive regulations promulgated for the purpose of carrying a statute into effect must be within the framework of the Act and may not be inconsistent with the statute." This same reasoning was advanced by the District Court in Warner Construction Company v. Krug, Secretary of the Interior (80 F. Supp. 81) wherein that court stated that "...[i]t is elementary law that executive regulations promulgated for the purpose of carrying a statute into effect must be within the framework of the Act and may not be inconsistent with the statute." (Emphasis added.)

Thus, a statute supersedes a Presidential Executive Order when in conflict and, notwithstanding the Presidential Executive Order regarding a government hiring freeze, the Secretary, pursuant to 38, U.S.C., 2003 and 2003A, is mandated to fill the Veterans Employment Service field, clerical, and Disabled Veterans Outreach Program positions.

Your comments on our position will be greatly appreciated.

Sincerely yours,

James G. Bourie
JAMES G. BOURIE
Director for Economics

ADDENDUM TO STATEMENT OF
E. PHILIP RIGGIN

The American Legion appreciates this opportunity to submit an addendum to its statement of March 16, 1981, concerning the proposed budget of the Department of Labor for Fiscal Year 1982 as it relates to veterans programs.

The Department of Labor in Fiscal Year 1982 has proposed the elimination of 52 secretarial positions for the State Directors for Veterans Employment Service, effectuating a cost savings of approximately 746 thousand dollars. These secretarial positions are critical to the effective implementation of veterans employment programs. Our statement of March 16 impressed upon the Subcommittee the importance of the secretaries, and we again take this opportunity to emphasize that State Directors for Veterans Employment would be severely handicapped without clerical support.

The Department of Labor advances the argument that PL 96-466, enacted in October of 1980, provides only "clerical" support to be given State Directors and that there is no mention, specifically, of "secretarial" positions. Also, that the wording of Section 2002A of Title 38, USC, as it relates to the clerical support positions is, in effect, a "loop-hole." Labor agrees that State Directors will still have clerical positions; however, these positions and the funding will be provided by the Job Service. This is difficult to rationalize since the Job Service will be cut 150 million dollars for FY82 resulting in the loss of approximately 10,000 personnel and will necessitate Job Service office closings nationwide. The Service simply will not have the funds nor the personnel to assign to State Directors. Importantly, they will not have the inclination to do so. Elimination of the secretarial positions will retard the veterans employment programs to a level of backlog and inefficiency should State Directors have no clerical support. We therefore respectfully urge this Subcommittee to recommend specific funding for the 52 secretarial positions be included in the Department of Labor's FY82 budget.

Mr. Chairman, of grave concern to us is the future of the Disabled Veterans Outreach Program. The American Legion and other service organizations fought long and hard to ensure that this program became reality. It did, and its worth and return to not only the government, but to disabled veterans was proven time and again. PL 96-466 transformed this program from an administrative program to a statutory one and, based on current Veterans Administration figures, one which would require approximately 2,000 nationwide staffers. Presently, there are approximately 1,400 staffers; however, the Department of Labor will be short 7 million dollars to fund the program to the end of FY81. The Office of Management and Budget has yet to reveal either the staff level or funds to be available for FY82, but for a nation wide level of 2,000 positions, 47 million dollars will be needed. Nonetheless, OMB has proposed that the 2,000 positions and their funding be, once again, taken from the Job Service.

Mr. Chairman, it is difficult to comment in depth since OMB has hailed to reveal its plans for the Disabled Veterans Outreach Program. It is generally agreed, however, that OMB will not recommend a full 2,000 personnel level. Should this be so, OMB would have placed themselves above federal law. We can only urge the Subcommittee to recommend the full 47 million dollars for the Disabled Veterans Outreach Program in FY82.

Thank you for allowing the American Legion to submit this addendum.

STATEMENT OF DR. DOLORES A. DAVIS-WONG

Mr. Chairman and members of the Labor, Health and Human Services and Education Subcommittee, I appreciate the opportunity to testify on behalf of the National Caucus and Center on Black Aged. I realize that your time is limited. Consequently, I shall keep my testimony brief.

At the outset, I want to stress that NCBA fully recognizes that the mood of the Congress is to reduce federal spending, and not to increase it. However, NCBA believes that it is important for the Congress to look at each program carefully on its own merits. In many cases -- if not most cases -- the Congress may decide that it is essential to hold the line or perhaps reduce spending for particular programs. But, any balanced view of federal programs requires a recognition that certain programs deserve well-timed and well-conceived funding increases because of special circumstances, national priority goals, or overriding needs to be met. This is true, even though the overall federal budget may be cut substantially in fiscal year 1982.

However, our Nation cannot close its eyes to readily pressing problems. We may not be able to grapple with them as soon as we would prefer. But, we simply cannot ignore them or sweep them under the rug and pretend that they do not exist.

The economic situation of the elderly -- and especially Black older Americans -- is deteriorating markedly. In 1979, nearly 500,000 persons 55 or older were added to the poverty rolls, including 400,000 individuals 65 years or older. This represents the largest increase for the elderly since poverty statistics were first tabulated about 20 years ago. Figures are not yet available for 1980. Many experts, though, are projecting another substantial rise in poverty -- perhaps of the same magnitude that occurred in 1979. The bottom line is that we may see nearly 700,000 to 1 million more persons 55 or older added to the poverty rolls from 1978 to 1980.

The bleak economic conditions for older Americans can generally be multiplied two or three times for Black older Americans because they suffer from multiple jeopardy since they are old, Black, and quite often poor. Older Blacks are almost three times as likely to be poor as elderly Whites. About 36 percent of all Blacks 65 or older live in poverty, compared to 13 percent for elderly Whites. In 1979, 55,000 older Blacks were added to the poverty rolls, raising the total from 662,000 to 717,000. This represents the highest number of impoverished older Black Americans since 1967, when 722,000 were poor. In addition, almost 300,000 aged Blacks had incomes between 100 percent and 125 percent of the poverty line. This means that 1 million Blacks 65 years or older are either poor or marginally poor. The net impact is that one out of every two Blacks (49 percent) either lives in poverty or so close to it that he or she really cannot appreciate the difference.

NCBA recognizes that older Americans -- perhaps more so than any other age group in our society -- are victimized by rapidly rising prices. It is essential, therefore, that our Nation gain a firm grip on the inflationary spiral. But, we must also remember that the most serious problem for the elderly -- and especially for older Black Americans -- is inadequate income. A retirement income crisis now affects millions of older persons and threatens to engulf many more.

A clear need exists to improve income maintenance programs for the elderly, such as Supplemental Security Income, Social Security and others. This, of course, will almost certainly not occur during this Congress, given the strong momentum to reduce federal spending. However, modest increases can be targeted effectively and prudently to programs with high cost-benefit ratios.

Senior Community Service Employment Program

One program that clearly meets these strigent standards is the Title V Senior Community Service Employment program. Title V has been an enormously effective program, enabling older Americans to help themselves while helping others in their communities at the same time. It has been a well-administered program, free of fraud and abuse.

With poverty already on the rise -- and the likelihood of another substantial increase to be reported this year -- Title V needs to be expanded. It is clearly an effective weapon to combat poverty. Title V also deserves to be expanded because of its exceptional prior track record.

The evidence is clear and convincing that a substantial number of low-income persons 55 or older are ready, willing, and able to work in the SCSEP. This point has been made repeatedly at NCBA's Rural Senior Community Service Employment Program, which provides jobs for some of the most economically deprived persons in the entire United States. In some cases, our local projects in six Southern states (Alabama, Mississippi, Kentucky, Tennessee, North Carolina and Florida) have seven or eight applicants for each available position. The ratio could be much higher, but NCBA does not want to disappoint disadvantaged persons by raising their hopes -- only to have them shattered because no realistic job prospect exists.

Title V now provides jobs for about 52,250 low-income persons in a wide range of fulfilling and useful activities. In July, the program is scheduled to grow modestly, to 54,200 jobs. The Administration's fiscal 1982 budget, which begins July 1982 for Title V, requests $277.1 million for the SCSEP. This would simply maintain Title V at its same level for July 1981 -- at a time when poverty is rising rapidly for older persons. It could quite likely mean a cutback in positions because operating costs for the program -- such as transportation, Social Security payroll taxes, and other related expenditures -- are soaring. The Administration's average enrollee cost, though, has not increased to take into account these higher expenditures.

NCBA strongly believes that the SCSEP should be expanded to assist low-income older Americans who want and need employment. A very substantial increase in the number of jobs would clearly be justified, and the money would be well spent. But, given the budgetary realities, NCBA is proposing a $12.9 million increase, raising the Administration's request of $277.1 million to $290 million. This would boost the number of jobs by 2,550, from 54,200 to 56,750.

The value and worth of the SCSEP has been amply demonstrated over the years. Approximately 88 percent of SCSEP funds pay for workers' wages, fringe benefits, and related services. It has provided useful and fulfilling jobs for persons unemployed for long periods of time -- in some cases 8 to 10 years. It has provided essential services to communities with an insufficient tax base to respond to the needs of their citizens. And, it has provided an important stimulus to economically depressed rural areas.

But perhaps most important of all is the psychological rewards for economically disadvantaged older persons. NCBA has been told time and time again by the enrollees that their jobs have lifted their spirits to the point that they "feel like new persons."

The Senate Labor, Health and Human Services and Education Subcommittee has provided important leadership to enable the SCSEP to grow to its present level. NCBA is grateful for your past support and we urge your renewed support for our modest proposed increase for FY '82.

National Impact Programs

NCBA also urges the Subcommittee to restore $2.5 million in funding to the Title IV demonstration programs under the Older Americans Act. This would increase the appropriation to $15 million, the same amount that the Congress provided in fiscal year 1981.

The Title IV demonstration programs can be especially effective during a period of austerity. If funding for basic services will be essentially stabilized or perhaps reduced, then demonstration programs can be useful to develop cost-effective models for service providers to replicate to deliver services most economically to older persons.

Title IV demonstrations, though, can provide important dividends in other important ways. It can provide innovative models for the AoA network to use as a model to respond to day-to-day problems confronting older Americans, whether they live in the center cities, the suburbs, or rural areas.

In addition, the Title IV demonstrations can be an important tool to respond to growing service and economic problems confronting older Blacks and other minorities. The Title IV program for example, identifies several funding priorities, including meeting the special needs of low-income, minority, and rural older persons. These efforts can also help to implement the mandate in the Older Americans Act that social services should be targeted to older persons with the "greatest economic or social need."

The funding for Title IV demonstration programs has been quite modest during the history of the Older Americans Act. But, the results have been impressive, including the congregate meals program, the home-delivered meals program, and many others.

Ideally speaking, this program should be expanded because of its high potential payoff in terms of improving service delivery and responding to the fundamental needs of older persons. NCBA only seeks to maintain the program at its fiscal 1981 level because of the tight budgetary situation. We sincerely believe that it would be a tragic mistake to cut the program by almost 17 percent, or $2.5 million -- especially when it can produce a multiplier effect to deliver services to additional older persons more effectively, efficiently, and economically.

Conclusion

NCBA urges the Subcommittee to adopt these modest proposals to assure that progress continues to be made in response to the growing problems confronting older persons. We believe these recommendations are realistic. They represent a cost effective way to come to grips with serious problems affecting older Americans. We reaffirm our support for these measures and call upon the Subcommittee to approve them.

Statement of Betty Duskin

Mr. Chairman, Members of the Subcommittee, I am Betty Duskin, Director of Research of the National Council of Senior Citizens. The National Council is a nonprofit, nonpartisan organization of 4,000 senior citizens clubs located in every state of the Union. The goal of the National Council is to serve not as a special interest group, but to seek a better life for older people in harmony with the national interest.

Therefore, we have a special commitment to the Senior Community Service Employment Program which serves not only the needy older people, but also the needs of society. We are proud to have been instrumental in the birth and growth of the program, and are especially proud of our role as a national organization

involved in making the program work efficiently and in meeting the goals of the Congressional mandate.

> In order to foster and promote useful part-time opportunities in community service activities for unemployed low-income persons who are 55 years old and who have poor employment prospects, the Secretary of Labor is authorized to establish an older Americans community service employment program.

This statement is taken from the opening paragraph of Title V of the Older Americans Act. Although the goals of the program were many, two major objectives emerged: to provide useful work for elderly people who need it the most, and to mesh the needs of older people with the need for community services in such a way that both would prosper.

The NCSC began its Senior AIDES Program with both of these goals clearly in mind. It has long been our deep feeling that the wholesale elimination of aged persons from the work force--people that have spent a lifetime working, communicating, and learning about life--is wasteful, inefficient, and unfair. As Adlai E. Stevenson said:

> What a man knows at 50 that he did not know at 20 is, for the most part, incommunicable. The knowledge that he has acquired with age is not the knowledge of formulas or forms or words, but of people, places, action--a knowledge not gained by words, but by touch, sight, sound, victories, failures, sleeplessness, devotion, love--the experiences and emotions of this earth and one's self and of other men and perhaps, too, a little faith and a little reverence for the things you cannot see.

This is not the type of experience our society can afford to ignore, especially in an impulsive, youth-oriented society such as ours.

With this as our prevailing attitude, we chose to call our Title V enrollees Senior Aides. AIDE is an acronym standing for alert, industrious, dedicated, energetic service, and our people are all of these. In fact, the impressive performance of the Title V program must be attributed to the thousands of older Americans who provide their time and talent to making the program work.

Currently, the Council as one of the eight national contractors, employs 10,300 Senior Aides in 127 projects around the country. Their duties are as varied as the work that needs to be done. We have people working as: paralegal assistants, home health and home repair aides, friendly visitors, meals-on-wheels workers, senior center aides, etc., all of which are vital services for the community. The average rate of pay is $3.45 an hour for program participants. Over 37 percent of our project participants are members of a minority group and over 78 percent are women.

We believe that the Senior AIDES program serves several important purposes: it finds jobs for low-income elderly people; it brings the elderly back into the mainstream of life, restoring dignity and returning mature minds and skills to the service of the community; and it fills jobs that need doing, satisfying unmet needs in the local community. The high employability of many older persons and the useful part-time work they can perform benefits the elderly and the community.

At a time of high unemployment, the Senior AIDES program offers a means both to provide jobs and increase productivity. Senior Aides come from the ranks of unemployed older persons, 55 and older with incomes at or below the poverty threshold. They are hired to work part time at prevailing wages on useful jobs in community service agencies, work that would otherwise not be performed.

Moreover, Senior Aides are not competitive with and do not collide with employment of Americans in other age groups. Aides perform useful, necessary community-services work, but work for which no other money is available. Aides fill those gaps. Much of the work is in service to the elderly, demand for which can be expected to grow as the older segment of the population increases.

It is important to recognize that the Senior AIDES program is not welfare. To the contrary, Aides are often elderly who are eligible for welfare but who are instead provided with employment. The money they receive is wages for work performed. Clearly, if their income were not supplemented through wages, it would be supplemented by various public assistance programs, since eligibility for the SCSEP requires low income status. From this point of view, it can be said that the program really costs nothing since monies would be spent on behalf of these same people in its absence.

It is also not a "make work" program--all jobs are badly needed community services. Senior Aides are in an employment program, not a welfare program.

The combined Title V programs provide jobs for a small portion of the 10.7 million elderly near or at poverty level. The cost of otherwise supporting the elderly poor is huge. Income maintenance programs continue to grow. Medicaid and housing costs have soared. Putting the able-bodied elderly to work instead of out to a poor pasture saves the nation a vast amount: Aides' wages diminish the need for other types of public benefits. And the nation receives a bonus: higher productivity and increased services.

The problem of the elderly poor is likely to be here for a long time. The proportion of the U.S. population 55 and older is rising, particularly the very old. Moreover, high unemployment persists. The age group 55+ will continue among the hardest hit, victimized by age discrimination and by a changing labor market. The cost of living keeps rising and contrary to the widespread perception that the elderly are protected, this is not the case. Only income from Social Security is indexed; other sources of pension income are not indexed! And Social Security is not fully indexed--indexing after a 14-month lag can hardly be called full indexing. For the great majority, pension income is terribly inadequate and with continuing inflation, it will become even less adequate. The need for a program like the Senior Community Service Employment program becomes even more important.

Finally, the effect of employment on the Senior Aides themselves must be mentioned. These are elderly who are recycled from being jobless, dependent individual into useful, productive, independent citizens. There is a tremendously positive effect on the aides knowing that they are useful, wanted and dependent upon by others. Aides serve themselves and the community.

All the positive outcomes--increased employment, decreases in the need for public benefits, performance of necessary jobs, heightening of self-respect--are indicative of how well Title V is working. Therefore, we ask this Committee to maintain all the jobs this program currently offers to the elderly poor and to those they serve and to be generous to those who wait for the opportunities, this program could offer them.

STATEMENT OF WILBUR J. COHEN

I am Wilbur J. Cohen, the Sid W. Richardson Professor of Public Affairs at the L.B.J. School of Public Affairs, The University of Texas at Austin, where I teach in the Human Services program. I was a member of the National Commission on Social Security (1977-81), and was Chairman of the National Commission on Unemployment Compensation (1977-80).

I was a staff member of the Committee on Economic Security (1934-35) which prepared the Economic Security bill which became the Social Security Act of 1935. I worked for the Social Security Board (1935-55) becoming Director of Research and Statistics. I was the Assistant Secretary for Legislation (1961-65), Under Secretary (1965-68), and Secretary of HEW (1968-69).

I am appearing here today in my individual capacity. I am available to answer questions on social security, and unemployment insurance and related matters which fall within the jurisdiction of this Committee.

In a brief statement such as this, it is not possible to include all of the analysis or justification for every recommendation. Hence, I will summarize my conclusions and be available to answer questions on any aspects of interest to the Committee members.

General Principles

Before discussing specific financing and benefit issues, I think it desirable to provide the framework of general principles which I support and which serve to provide the basis for answers to specific issues.

I view the OASDHI program as a social insurance system. It is not a welfare program although its objective in Constitutional terms is to promote the general welfare. It is not a private insurance system. But it is a contributory social insurance program with earmarked payroll taxes to support specific statutory benefits. The entitlement to such benefits is a compact which the elected representatives of the people have written into specific promises in a law similar to the policy which an individual receives from a private insurance company.

Millions of people contributed to this insurance system for many years which they believed would pay them for the promised benefits as a matter of statutory right. In my opinion, reduction or repeal of a statutory insurance promise may result in many individuals losing faith in the integrity of the Congress and their Government. Already many young people believe they will never receive the benefits promised. Cutbacks in benefits will reinforce and extend this belief. Such a consequence would be unfortunate.

Moreover, if the confidence of large numbers of the public in the financial integrity of the system is weakened or destroyed, the result may be to undermine the entire contributory nature of the system and eventually to result in converting the program into a wholly general revenue financed system. I would not want this to happen. And, I believe it is too big a risk to take by considering benefit cutbacks through the Reconciliation process. It would be difficult to persuade contributors that their contributory benefit could be wiped out by a Budgetary process which did not take into account the moral, political and economic commitments they believe are embodied in the system.

Moreover, millions of contributors do not understand how the earmarked taxes and benefits of this system became involved in the general Budget or deficits in the general revenues.

In my opinion, the public does not view the Social Security system as a macro-economic income transfer program as do most economists. I doubt whether they want it mixed up with the economists' theories of either supply policy or otherwise. I urge that you should not determine the financing or benefit relationship of the program based solely or primarily on short-run budgetary or fiscal considerations.

Recent public opinion polls show that most persons treat Social Security, as did Senator Robert Taft, as an exception to general tax or government benefit policies. In my opinion, there would be no support for payroll taxes unless the benefits were earmarked and paid as a matter of statutory right. Conversely, major policy changes in the benefit structure could undermine support for the contributory approach embodied in the present law.

Congress over the past 45 years has reaffirmed its support and belief in the contributory social insurance philosophy. It has done so at least on 17 major occasions. I strongly urge the Congress to do so again this year.

I favor:

1. Inter-fund borrowing;

2. Authorization for borrowing, with interest, from the general fund for limited periods;

3. Reenactment of the Vandenberg amendment (1944-50) which authorized appropriations from the general fund to assure

full payment of promised benefits to help in reestablishing confidence in the program;

4. Payment of up to one-half of the cost of the Medicare program from general revenues and allocation of the released payroll contirbutions to OASDI program, such cost to be considered as part of the 1981 tax reduction package;

5. A specified tax credit for employer, employee and self-employed contributions, such an offset to be considered as part of the 1981 tax reduction package;

6. Extension of coverage to the President, Vice-President, Members of Congress, and persons confirmed by the Senate, including the Commissioner of Social Security;

7. Coverage of Medicare to all Federal Employees;

8. Reestablishment of a Social Security Board and separation of its functions from the Department of Health and Human Services;

9. Exclusion of Social Security payroll contributions and expenditures from the Federal Unified Budget; and

10. Establishment of a Special Social Security Court (similar to the Tax Court) to handle the growing number of appeals.

In my judgment, these several actions taken together would help to reestablish public confidence in the financial and administrative integrity of the Social Security program. This objective is the most important action you can take at this time. It is the highest priority and the most urgent necessity.

I am opposed to:

11. Any change in the basic methods of indexing wages for benefit computation purposes by substituting price changes for wage changes;

12. Any change in the basic cost-of-living indexing for Social Security beneficiaries unless it is based upon professionally sound recommendations and is consistently applicable to other Federal benefit programs;

13. Making the basic coverage of the Social Security System voluntary;

14. Any proposal which would provide for 100% general revenue financing for any benefit program because I believe it would inevitably result in the transformation of such benefit into being considered "welfare" or being income-conditioned and thus serving as further discontent over the earmarked payroll contributions to the system;

15. Any proposal which attempts to eliminate one so-called inequity in the law by reducing the benefits to another group such as between single or married women, or men and women;

16. Any proposal which attempts to establish a "double-decker" benefit program by separating out a general revenue financed benefit from a contributory financed benefit.

17. Any increase in the normal retirement age from 65 to 68 for cash benefits and/or Medicare, or any increase in the actuarial reduction option from age 62 to 65;

18. The three reductions in benefits recently proposed by President Reagan, to be effective this year, namely with respect to the insurance payments to the children between ages 18-22 of retired, deceased or disabled contributors, further disability insurance requirements, and the repeal of existing minimum insurance benefits of $122 a month.

Other Issues

There a number of other issues which have arisen which merit consideration. I would like to comment on some which have been advanced recently.

Return the Program To Its Original Purpose

One of the frequently heard statements is that the program should be returned to its original purpose, namely the payment of benefits solely to older people, and any other benefits should be considered as welfare, and paid from general revenues.

I am opposed to this approach for the reason I have already pointed out. But there are additional considerations which support my view.

The Committee on Economic Security which drafted the original legislation was interested in a program which included old age, survivors, and disability benefits. They studied the foreign systems which provided all three aspects. But because of the economic conditions in 1935 and the absence of any Constitutional certainty about the program, they believed it desirable to postpone action on monthly survivor and disability benefits.

Some of the studies of the staff of the Committee on Economic Security will be found in Social Security In America, 1937, pp. 459-497; references to other studies will be found at pp. 525-530.

In addition, I would like to point out that the disability benefits are premature retirement benefits and the survivor benefits (life insruance) are payable because of the permanent retirement of the contributor. Medicare is primarily to cover the major medical care costs of retired persons whose monthly income cannot adequately handle unpredictable and catastrophic costs. All these benefits, in my judgment, are essentially broadly defined retirement type coverage, including the benefits to both young widows with children and older widows. They are a logical and consistent package. And, I strongly believe they should be kept together.

There is one aspect of the original purpose of the 1935 old age insurance program which I believe should be retained and that is the retirement test. However, I recognize that this is one increase in expenditures which President Reagan has endorsed, and which many persons support. However, I urge you not to increase the cost of the program for this purpose. If the Congress does decide at some later date to increase or repeal the retirement test, I would urge that one-half of the cost of any such legislative action should be met from general revenues rather than from payroll taxes.

Similarly, while I am opposed to any exemption from the employer, employee, or self-employed tax on behalf of anyone age 65 or over, if Congress does decide to do so, one-half of such revenue loss to the system should be reimbursed from general revenues.

In any case, I would urge that this is not an appropriate time to increase the benefit cost or the revenue loss of the system. This is the safest point of view to be taken at this time.

The Inter-Generational Compact

The financing of the present program is basically on a pay-as-you-go basis with a contingency reserve.

I would prefer to build up the reserves somewhat to cover the ups and downs of the business cycles, errors in the estimates, and short-run difficulties.

Essentially, however, the system should be continued so that extraordinarily large reserves are not accumulated. This necessitates convincing contributors that the current working generation pays the contributions for the beneficiary generation.

I believe it is essential to reinforce the principle of the inter-generational financing and benefit compact. I recognize the difficulties involved in convincing young persons to contribute to the program. But that is why we should retain and preserve the life insurance and disability insurance benefits in the program so that younger and middle-aged workers will have valuable protection in relation to their contributions and their risks of dying or becoming disabled in addition to reaching old age.

Preserving the Financial Soundness of the Program

I wholeheartedly support the effort to provide sufficient income to the system to pay the promised benefits in the existing law. While I support and prefer to finance the present benefit provisions with a supplementation from general revenues equal to one-half of Medicare costs, I recognize that some other combinations are feasible. One possibility would be to phase in such general revenues over a five year period combined with some modification in existing payroll taxes, depending upon the expectation and assumptions of economic recovery in the future, and the extent of general tax reductions.

I would also support a payment from general revenues equal to the loss of contributions to the system during the period when unemployment exceeds a specified level, such as 5 or 6 percent. Such a proposal was advocated in 1977 but not accepted by the Congress. It is, however, worthy of further consideration since it is a proposal which to an appreciable extent has a realistic built-in cost limitation not related to future increasing beneficiary liabilities.

General Revenues

I recognize the political and financial problems involved in providing that one-half of the Medicare costs borne out of general revenues. I will try to sort out some of these problems.

First, about 70% of the cost of that portion of Medicare related to physicians' insurance coverage is borne out of general revenues. There has been no impairment of the contributory or insurance features as a result of this policy instituted in 1965.

Since Medicare benefits are not related to prior earnings levels, it is reasonable to utilize some general revenues in that aspect without impairing the philosophy related to the case earnings related benefits.

Finally, it is timely and appropriate to consider any general revenue contribution to the system as an offset to any general tax reduction to individuals and employers which would otherwise have been necessary by an increase in payroll taxes.

An Income Test?

Some individuals have advanced the proposition that the benefit liability of the system could and should be reduced by eliminating payments to the very rich or restricting them to the truly needy.

I would vigorously oppose any such change in the law. No matter where the income limit originally was set, it would result sooner or later in the program becoming considered by the public as a "welfare" program. It would result in an inevitable change in the contributory earnings related program.

The fundamental objective of the system is to pay benefits when there is a loss of earnings due to retirement, death, or disability. It is true that some--even many--persons will receive the benefits who don't really need them just as any insurance system does whether fire insurance or automobile insurance.

Conclusion

I have presented a number of recommendations to restore the financial integrity of the Social Security system to preserve public confidence in the Congressional responsibility for a program affecting millions of people. Not everyone will concur in every aspect, but I believe the proposals I have made are feasible and sound and, if instituted, will merit the support of a large number of people in organizations which support the Social Security program.

I have in recent weeks talked with a number of people representing many different organizations and points of view. The benefit reductions proposed by the Administration have resulted in anxiety primarily because it is recognized that if you can cut one benefit today, you have established a precedent to enable you to cut another benefit tomorrow; if you cut a little here, you can cut a little more later;

if you cut out young people today, you can cut them out when they get old. If you can cut out a student or disabled person today, you can cut out a retired person tomorrow. This is the danger which contributors and voters perceive as a very real possibility.

I urge you, therefore, to finance the benefits in the present law. You may not think every benefit in the law is as valuable or essential an another. What is unimportant to Mr. Stockman may be important to a widow, a disabled person or a student. We must not be penny-wise and pound foolish.

I particularly wish to point out that recommendations to change social insurance benefits rights, effective only a few months away, will be particularly a vulnerable action. I strongly urge action on a sound financing program and opposition to proposals to repeal what are in effect the vested benefit rights of contributors to the system.

STATEMENT OF JON WEINTRAUB, ASSOCIATE DIRECTOR AND LEGISLATIVE COORDINATOR, NATIONAL ASSOCIATION OF COUNTIES

Senator SCHMITT. In the next panel is Jon Weintraub, Associate Director and Legislative Coordinator, National Association of Counties; Ruth E. Kobell, Legislative Assistant, National Farmers Union; and Sydney Howe, Executive Director, Human Environment Center. Your prepared statements will be printed in their entirety after your oral presentations.

If I mispronounced your names, don't hesitate to correct me.

I will, if it doesn't make you all feel too uncomfortable, if I can watch my little watch here, my special astronaut watch, pound the gavel when you have 1 minute left in your presentations. I'm not a very good disciplinarian, but I'll try.

Jon Weintraub first, please.

Mr. WEINTRAUB. OK. Mr. Chairman, my name is Jon Weintraub. I'm with the National Association of Counties. At our national legislative conference last week the NACO Board of Directors decided on positions regarding various budget cuts.

Senator SCHMITT. Excuse me, Jon, in case anybody is watching this light, that's a 15-minute clock.

Mr. WEINTRAUB. Specifically, our board decided what cuts we could live with, what cuts we must oppose, and what cuts we might suggest in lieu of some of the cuts that the President suggested.

In the area of employment policy, first off, we are willing to accept the cut in title VI public service jobs as well as the variety of others listed below in my statement; but would oppose cuts in the title II-B public service jobs programs and any cuts in your basic training titles.

In exchange for that opposition, we are suggesting several areas of other cuts that could come and subsidize these programs. One, to eliminate the work incentive program, and two, to tax unemployment benefits after an individual's income, including those benefits exceeding 125 percent of the BLS lower living standard.

As you can see, our opposition is primarily centered on the training programs, both in the youth area and the II-D public service jobs which primarily directs itself to welfare recipients. We understand the President is about to suggest a work fair program and it seems ridiculous to dismantle your program that provides public jobs to welfare recipients at the same time on a separate track.

You're establishing a new program for public service jobs for welfare recipients. We are concerned, however, in terms of the overall process of these cuts and feel very strongly that if Congress makes cuts in certain areas they must take responsibility for the liability created by those cuts. For example, there are a number of requirements in the CETA law that simply cannot be met by a drastic phasedown of the public service jobs programs.

We feel that those changes which I have listed in my testimony need to be corrected legislatively, either in your reconciliation bill or some other process. We can only look to last year's reconciliation bill which eliminated UI benefits for public service jobholders and point out the disaster that that has caused within the system. In terms of other ideas we support the Department's request to reprogram 245 million PSE funds to pay UI benefits and suggest there are a couple of areas that this committee could look at that would help us out. One in the area of the various reports. Currently there are layers and layers of reports required of CETA prime sponsors. What we would ask of you is to ask the Labor Department for a list of those reports and what data bases those yield and see if some simplification could be achieved; and, two, just to highlight in this list, we are quite concerned with the amount of time, both at the prime sponsor level and of DOL staff time, used to produce over 400 field memorandums a year.

This is more than one per day including Sundays and holidays that the system must react to. in the area of MSHA training funds, we support the retention of current prohibition for spending MSHA appropriations for training planned compliance.

Just highlighting in the human service areas, we are supportive of your basic social services block grant as long as that does not transfer costs to cities and counties.

With regard to refugee programs, we support full Federal funding of refugee resettlement costs. There are a number of counties across the country that have large concentrations of refugees and we submit that this is a Federal problem and should not be borne out of local tax dollars.

Senator SCHMITT. That's 5 minutes.

Mr. WEINTRAUB. Thank you.

Senator SCHMITT. The remainder of your testimony will be included in the record.

Mr. WEINTRAUB. Thank you.

Senator SCHMITT. Next, Ruth Kobell.

STATEMENT OF RUTH E. KOBELL, LEGISLATIVE ASSISTANT, NATIONAL FARMERS UNION

Ms. KOBELL. I appreciate the opportunity to be with you. You already had two witnesses who spoke to title V of the Older Americans Act, which is the senior community service employment program, and I want to very briefly add my comments because I have included some history of how National Farmers Union, a farm organization, came to sponsor green thumb, this is an employment program for older low-income people who carry on projects in rural communities.

We believe that in the 15 years since this program was started and has now expanded to eight national organizations and the Governors, that there has been an important demonstration made of the use of older people in productive work in our society, and we believe this is very important because we all recognize that older Americans are a very fast-growing part of our community. We have built up a pattern of retirement, of putting them on the shelf or in the rocking chair, and we think that before too long we must simply from economic as well as social point of view, see that we can continue to make use of their work. We have demonstrated issues by using the skills and experience and commitment of often the oldest and most economically disadvantaged. Those people who have the least opportunity for employment.

I have reviewed in my statement some of the kinds of work that we have done and I have included a copy of a report that goes to the Labor Department to outline the wide variety of projects that have been developed over the years.

Originally we started out with highway beautification and parks, but as one newspaper person said, green thumb doesn't just plant trees. It nurtures lives. We think this is right because the contribution that's made when people are allowed to work is an exciting kind of thing. We're talking about making people work.

We find that the long list of people who want to get a job in green thumb, even though it's part time, minimum wage, demonstrates the fact that they very much want to make a contribution. We think the fact that they are doing things that would not otherwise be done adds to the gross national product. They pay taxes. Green thumb itself writes checks for more than $1 million a month for social security and income taxes for their workers and their staff.

Many of the people that we employ were not able to earn full social security. Some of them weren't able to earn any social security. So the fact that they work on this program means that they actually earn social credits which, itself, is an important kind of contribution in this effort to cut back on her programs that have grown because we've had high unemployment and high interest rates, high inflation rates.

I don't want to take any more time because I know you're under heavy pressure with a lot of witnesses. I do want to join other sponsors in saying we hope that in your review of appropriations you will see fit to keep this program at the level of jobs now provided in the program, even though that may involve a little more money for the inflation costs that all of us are so anxious to control.

I will be glad to provide any additional information the staff may find use.

Senator SCHMITT. Thank you very much. Sydney Howe, Executive Director, Human Environment Center.

STATEMENT OF SYDNEY HOWE, EXECUTIVE DIRECTOR, HUMAN ENVIRONMENT CENTER

Mr. HOWE. Thank you, Mr. Chairman. I want to simply summarize a few points from the testimony I've submitted for the record.

I'm speaking particularly, if not exclusively, to the appropriation for the Young Adult Conservation Corps title VIII of CETA. I would emphasize the bipartisan nature of national support for young conservation employment.

We have been investigating this subject for many months and we find a surprising show of interest from both sides of the isle in this Chamber and the other one. We find anew a joint interest of major environmental and human resources interests throughout the country. This common interest has never emerged in past discussions of YACC. It is strong today and growing. There is recognition that youth employment which conserves the land and does something significant about the terrible tragedy of unemployed youth is a common interest of the landscape and our people.

The reversal, or let's say the new trend, as illustrated in the 28-group statement I have attached to my testimony, major national organizations from environment and human resources context, joining to say, as I say now, please reverse the deferral of $58 million from current YACC expenditures, and we shall add, please appropriate $275 million or more for fiscal 1982.

YACC is a service program. Its nomenclature and nature may have been misplaced in the CETA context because one of its great benefits is, as I have said, to the land, to the natural resources of our wild lands, rural lands, and our urban built resources. It is serving young men and women all over the country.

Perhaps as important as any factor in this time of budget stringency, it is almost literally making money. The fact that 1.34 dollars' worth of product is obtained by the U.S. Forest Service for every $1 that's spent to mount a YACC crew in forest service should be a rather startling fact for anyone cutting budget for forest operation.

Similar figures apply across the Interior Department and in the State agencies mounting YACC programs. These figures apply without one whiff of notice to the social benefits of young people given new confidence, new ability to work, and certain training despite the fact that this program is not directed as a training program.

The potentials for YACC's future are immense. They have hardly been explored in part because this program has been buried. It is fully—it is quite possibly a program that can capture and let the American spirit as its predecessor, CCC, did in the 1930's with bipartisan support. It could do much more for youth in poverty. It could have a much larger component of State responsibility in its operations in tune with the State orientation of this—the new administration. It could do much more to engage business and organized labor in its operations, and in doing so, to impart skills to the youth involved and assure strong placement for them after their enrollment period.

It could even begin to do that job on discarded private lands across this country. For example, in woodlot improvement, the forest industries have told us for years the biggest future resource is in decent management of small woodlots across this country. If that could become affordable by youth crews doing the work, cost-sharing by landowners and public cost-sharing because of public benefits, it would be a great accomplishment. It could extend into erosion control, wildlife habitat improvements, stream life protection, many neglected but valuable improvements to the land that bring both public and private benefit.

The dismantling of YACC as proposed in the administration's budget would be a tragedy. The wording attached to the figures in the administration's budget statement is absolutely misleading. It ignores the great strengths of this program that are being demonstrated in many, many places, urban and rural. It ignores the need in these times for such a program that engages youth and serves conservation.

It would be a waste of an infrastructure operating and in place with the high promise I have described—a trained cadre to supervise facilities and equipment all down the rathole.

We ask you to end the $58 million deferral now damaging this program and its morale and its functions and to appropriate $275 million or more for fiscal 1982. Thank you.

Senator SCHMITT. Thank you. We appreciate the panel's testimony.

[The statements follow:]

STATEMENT OF JON WEINTRAUB

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, MY NAME IS JON WEINTRAUB. I AM AN ASSOCIATE DIRECTOR AND LEGISLATIVE COORDINATOR OF THE NATIONAL ASSOCIATION OF COUNTIES.*

LET ME BEGIN BY EXPRESSING TO THE SUBCOMMITTEE OUR TOTAL UNDERSTANDING OF THE IMPORTANCE THESE HEARINGS HAVE IN OUR ORGANIZATION'S ABILITY TO REFLECT OUR CONCERN OVER THE FEDERAL BUDGET FOR FISCAL 1981 AND 1982.

THE MEMBERSHIP OF NACo HAS BEEN CONCERNED FOR SOMETIME ABOUT THE SIZE OF THE FEDERAL BUDGET AND THREE YEARS AGO FORMALLY ADOPTED A RESOLUTION URGING FEDERAL, STATE AND LOCAL GOVERNMENTS TO FORM A PARTNERSHIP AND IMMEDIATELY BEGIN A SINCERE EFFORT LEADING ULTIMATELY TO A BALANCED FEDERAL BUDGET. AT THE SAME TIME,WE CHANGED THE INTERNAL PROCEDURES OF OUR POLICY-MAKING PROCESS AT NACo, BY REQUIRING THAT WHEN OUR STEERING COMMITTEES REVIEW A NEW OR CONTINUING FEDERAL PROGRAM, THAT PROGRAM MUST BE ACCOMPANIED BY A FISCAL NOTE. IN TAKING ACTION, THE STEERING COMMITTEE MUST CONSIDER THE FISCAL NOTE. THE MATTER IS AGAIN REVIEWED BY OUR RESOLUTIONS COMMITTEE AT OUR ANNUAL MEETING AS INDIVIDUAL PROGRAMS ARE CONSIDERED AND ACTED UPON PRIOR TO THEIR BEING FORWARDED TO OUR GENERAL MEMBERSHIP MEETING FOR FINAL ACTION. WE BELIEVE THIS PROCESS IS WORKING AND THAT AS A RESULT, NACo IS NOW TAKING MORE RESPONSIBLE POSITIONS ON FEDERAL SPENDING LEGISLATION.

AT OUR ANNUAL LEGISLATIVE CONFERENCE LAST WEEK (MARCH 8-10,1981), THE NACo BOARD OF DIRECTORS APPROVED RECOMMENDATIONS OF EACH OF OUR TWELVE STEERING COMMITTEES OUTLINING WHICH OF PRESIDENT REAGAN'S CUTS WE CAN ACCEPT, WHICH WE MUST OPPOSE, AND WHAT CUTS WE CAN SUGGEST INSTEAD OF SOME OF THE CUTS BEING MADE.

EMPLOYMENT POLICY

IN THE AREA OF EMPLOYMENT POLICY,NACo HAS MADE THE FOLLOWING DECISIONS:

CUTS NACo CAN ACCEPT

- ELIMINATION OF 100,000 CETA TITLE VI PUBLIC SERVICE JOBS.
  ($153M IN FISCAL 1981; $1.09B IN FISCAL 1982 REDUCTION)
- CHANGES IN UNEMPLOYMENT INSURANCE LAWS AS PROPOSED BY THE PRESIDENT.
  ($1.1B IN FISCAL 1981 AND 1982)
- REDUCE STAFF FOR THE UNITED STATES EMPLOYMENT SERVICE.
  (CUT $150M IN FISCAL 1982)
- REDUCE THE WORK INCENTIVE PROGRAM.
  (CUT $20M IN FISCAL 1982)

CUTS NACo OPPOSES

- ANY CUTS IN CETA TITLE II-D PUBLIC SERVICE JOBS.
  ($689M IN FISCAL 1981 AND $2.25B IN FISCAL 1982)
- ANY CUTS IN CETA TITLES II-B, III, IV-A, IV-C, OR VII.

CUTS NACo SUGGESTS INSTEAD OF THE PRESIDENT'S CUTS

- ELIMINATE FUNDING FOR THE WORK INCENTIVE PROGRAM (WIN)
  ($385M IN FISCAL 1982)
- USE OF UNEMPLOYMENT INSURANCE BENEFITS AFTER 13 WEEKS FOR SUBSIDY OF JOB TRAINING OPPORTUNITIES AND WAGES FOR PUBLIC AND PRIVATE SECTOR JOBS.
- TAXATION OF UNEMPLOYMENT BENEFITS AFTER AN INDIVIDUAL'S INCOME, INCLUDING THOSE BENEFITS, EXCEEDS 125 PERCENT OF THE BUREAU OF LABOR STATISTICS LOWER LIVING STANDARD INCOME LEVEL.
  ($2.5B IN FISCAL 1982 SAVINGS)

AS YOU CAN SEE,WE OPPOSE THE COMPLETE ELIMINATION OF PUBLIC SERVICE JOBS. IF SOME OF THE PSE CUTS WILL GO THROUGH, PRIME SPONSORS WILL BE FACED WITH A MAJOR REDUCTION OF THEIR ADMINISTRATIVE COST POOLS. THEY HAVE ALREADY BEEN ORDERED TO STOP HIRING PARTICIPANTS, EVEN TO FILL CRUCIAL VACANCIES. A NUMBER OF BASIC REQUIREMENTS OF THE CETA LAW THEN SIMPLY CANNOT BE MET FOR EXAMPLE, THE REQUIREMENTS TO SPEND 20% OF TITLE II-D FOR TRAINING (SECTION 232(B)(2)(C), P.L.95-524) AND 50% OF TITLE VI FUNDS ON PROJECTS (SECTION 605(A),P.L.95-524) AND THE LIMITATION ON THE ADMINISTRATIVE COST POOL SIMPLY CANNOT BE MET THIS YEAR AND MUST BE WAIVED OR AMENDED SO THAT PRIME SPONSORS ARE NOT SUBJECT TO AUDIT LIABILITIES THAT ARE COMPLETELY BEYOND THEIR CONTROL.

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*THE NATIONAL ASSOCIATION OF COUNTIES IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN THE UNITED STATES. THROUGH ITS MEMBERSHIP, URBAN, SUBURBAN AND RURAL COUNTIES JOIN TOGETHER TO BUILD EFFECTIVE, RESPONSIVE COUNTY GOVERNMENTS. THE GOALS OF THE ORGANIZATION ARE: TO IMPROVE COUNTY GOVERNMENT; TO SERVE AS THE NATIONAL SPOKESMAN FOR COUNTY GOVERNMENTS; AND TO ACHIEVE PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

Should the Congress make these drastic PSE cuts, the Congress must also take the responsibility to amend or waive the law to protect prime sponsors from liability that the Congress creates. One only needs to look at the problems and confusion created by the elimination of FUBA funds for the unemployment insurance benefits for CETA-PSE workers that the Omnibus Reconciliation Act (Title X, Subtitle C, Section 1021 of P.L.96-499) created. This is a perfect example of how ill-conceived and incomplete congressional action hurts the prime sponsor delivery system and the clients it is designed to serve. We would ask you to urge the cooperation of the Senate Finance Committee to repeal Section 1020 of P.L. 96-499 in this year's reconciliation bill. Clearly, this change in FUBA did not result in a reduction in outlays and only shifted the burden for paying these UI benefits to CETA in the short term and to state and local governments in the long term.

These are areas in the implementation of CETA that, if changed, can create potential savings which can be directed to serving CETA clients. We ask this subcommittee to consider the following suggestions:

1. Ask DOL to give you a list of all of the various reports, both written and telephone/verbal, that DOL currently requires as well as what data elements each provides and how often the reports are required. Surely as a result of this process you will find that some reports could be eliminated. At the same time Congress could define the data and frequency of reports it actually needs and limit DOL to these.

   Unfortunately, we are living in a situation where reports have been layered on over each other with little evaluation of what is actually needed to monitor the program versus satisfying the desires of academicians and researchers.

2. Seek prime sponor and other testimony on the amount of staff time and money spent meeting the publication, review, and process requirements of Section 104 of P.L.95-524 versus the actual return of any comments, much less useful ones. We support an open, public employment and training system. We feel that this can be maintained with some curtailment of Section 104.

3. Review the use of, and the amount of DOL staff time used to produce DOL field memoranda and TWXs that add, modify or further interpret regulations or requirements affecting CETA prime sponsors. Certainly, the fact that the Department of Labor has issued an average of over 400 field memoranda (more than one per day including Sundays and Holidays) in each of the two fiscal years since the 1978 amendments violates the spirit, if not the intent, of Section 104(e)(2) of P.L.95-524.

4. Seek testimony on the desirability of one advisory council for the whole Act rather than the current situation where the prime sponsor must prepare for and staff a minimum of three separate councils, thus creating unnecessary administrative expenses.

5. Explore the viability of further program consolidation within the Act.

6. Explore the interpretation of P.L.95-524 in DOL regulations that require increased use of administrative costs to fund a full-time staff person for EEO in all prime sponsors regardless of size.

7. Review the expense of the implementation requirements of DOL in both regulations and review of plans that affect the independent monitoring units (IMUs).

These are just a few suggestions for the future. We look forward to working with the subcommittee in the 97th Congress to ensure the viability of an effective, streamlined employment and training system.

MSHA Training Funds

We support the retention of the current prohibition for spending MSHA appropriations on training plan compliance for the remainder of fiscal 1981 and in fiscal 1982. The MSHA training requirements are particularly inappropriate for county sand, gravel and stone pit operations which are primarily seasonal in use, generally involve employees working part-time, and almost exclusively connected with county road maintenance responsiblities. We appreciate your past policy on this issue and we encourage your continued support.

HUMAN SERVICES

AFDC

With regard to AFDC, NACo supports the Administration's proposals that would save $520 million in fiscal 1982. Specifically, standardizing the AFDC earnings deductions and placing a limit on the currently itemized, open-ended expenses, would contribute to better management of the program and help to ensure that benefits are going to the neediest. For counties to absorb funding cuts through reduced federal participation in the basic AFDC benefits, however, there would have to be major restructuring of the welfare system. We are, therefore, carefully reviewing welfare impact on counties, in anticipation of the Administration's proposed block grant approach. If the result of that approach would be to shift welfare costs to local governments, NACo could not support it.

SOCIAL SERVICES BLOCK GRANT

NACO CAN SUPPORT CONSOLIDATION OF SEVERAL CATEGORICAL GRANTS INTO ONE BLOCK GRANT. HOWEVER, THERE ARE MANY UNANSWERED QUESTIONS AS TO WHAT PROGRAMS ARE TO BE INCLUDED, AND THE CONDITIONS THAT WOULD BE IMPOSED, AND WHETHER A 25% REDUCTION OF THE CURRENT FEDERAL FISCAL COMMITMENT TO THESE PROGRAMS WOULD BE SO SEVERE AS TO UNDERMINE THE SERVICES PROVIDED UNDER THE BASIC BLOCK GRANT. THE TITLE XX SOCIAL SERVICES PROGRAM IS AN EXAMPLE OF AN AREA THAT MAY BE UNABLE TO TOLERATE THAT REDUCTION: IT IS ALREADY A BLOCK GRANT, AND AS SUCH HAS LONG SINCE CONSOLIDATED PROGRAMS, REDUCED OVERLAP AND DUPLICATION, AND ACHIEVED ADMINISTRATIVE SAVINGS THAT WOULD ACCRUE FROM CONSOLIDATION. ONE CANNOT REALISTICALLY EXPECT THAT A 25% FURTHER REDUCTION COULD BE MADE UP BY ADMINISTRATIVE SAVINGS. THOSE CUTS WOULD HAVE TO COME FROM PEOPLE RECEIVING SUCH SERVICES AS CHILD PROTECTION OR IN-HOME ASSISTANCE THAT PREVENTS INSTITUTIONAL CARE FOR THE ELDERLY.

IF A BLOCK GRANT IS ACCEPTED, ADEQUATE LEAD TIME IS NEEDED FOR COUNTIES AND STATES TO MODIFY PROGRAMS BEFORE THE FUNDS ARE CUT. IN ADDITION, COUNTIES NEED ASSURANCE THAT ADEQUATE FUNDS WOULD BE PASSED THROUGH TO COUNTIES TO PRESERVE VITAL SERVICES.

REFUGEE PROGRAMS

AT THIS POINT, IT IS NOT CLEAR WHAT THE ADMINISTRATION PROPOSED FOR REFUGEE FUNDING CUTS. NACO SUPPORTS FULL FEDERAL FUNDING FOR REFUGEE RESETTLEMENT COSTS. THESE COSTS, WHICH SHOULD BE SHARED BY ALL AMERICANS, FALL DISPROPORTIONATELY ON SOME STATES AND COUNTIES.

HEALTH PROGRAMS

IN THE AREA OF HEALTH, OUR CONCERNS ARE EQUALLY ACUTE. AS YOU KNOW, COUNTIES HAVE FAR-RANGING RESPONSIBILITIES FOR THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES. THEY PAY FOR A MAJOR PROPORTION OF HEALTH CARE COSTS INCURRED BY THE MORE THAN 46 MILLION AMERICANS—WHO EITHER HAVE NO HEALTH INSURANCE PROTECTION OR INADEQUATE COVERAGE. THEY OPERATE SOME 800 COUNTY HOSPITALS, 800 NURSING HOMES, 1800 LOCAL HEALTH DEPARTMENTS, HOME HEALTH AGENCIES AND MANY OTHER SERVICES. THE DEPARTMENT OF HHS HAS ESTIMATED THAT LOCAL GOVERNMENTS SPENT $8 BILLION ON HEALTH CARE IN FISCAL 1980. BECAUSE OF THIS EXTENSIVE COMMITMENT, COUNTY GOVERNMENTS HAVE SERIOUS CONCERNS ABOUT SOME OF THE ADMINISTRATION'S PROPOSED BUDGET CUTS IN HEALTH.

THE PRESIDENT HAS STATED THAT HE DOES NOT INTEND TO SHIFT THE BURDEN OF CUTS TO LOCALITIES. HE ALSO HAS STATED HIS INTENTION TO ASSURE THAT SPENDING CUTS NOT FALL DISPROPORTIONATELY ON COUNTY GOVERNMENTS OR ON NEEDY AMERICANS WHO MUST DEPEND ON THE "SAFETY NET" OF PROGRAMS DESIGNED TO PROTECT THEIR ACCESS TO THE BASIS NECESSITIES OF LIFE. WE ARE ALSO STRONGLY SUPPORTIVE OF THE EFFORTS TO ACHIEVE A BALANCED BUDGET AND PLEDGE TO WORK WITH YOU IN ALL POSSIBLE WAYS TO ATTAIN THAT GOAL. INFLATION AND SPENDING AT ALL LEVELS OF GOVERNMENT MUST BE BROUGHT UNDER CONTROL, AND IN ORDER TO DO SO, WE ACKNOWLEDGE THAT SOME PROGRAMS MUST BE RESTRUCTURED OR ELIMINATED WE WOULD CONCUR WITH THE PROPOSED CUT IN PSROS, AND HEALTH MANPOWER PROGRAMS, NOT BECAUSE WE BELIEVE THE PROGRAMS DO NOT HAVE CONSIDERABLE MERIT, BUT BECAUSE OF THE ORGANIZATION'S RECOGNITION OF THE OVERALL BUDGETARY GOAL.
OVERALL BUDGETARY GOAL.

HOWEVER, WE HAVE SERIOUS CONCERNS WITH PROPOSED CUTS IN MEDICAID AND HEALTH PLANNING. IN THE AREA OF MEDICAID, WE BELIEVE STRONGLY THAT THE MASSIVE $1-$2 BILLION CUT WHICH THE ADMINISTRATION IS SEEKING IN FISCAL 1982 WOULD INEVITABLY RESULT IN A SHIFTING OF THOSE COSTS TO LOCAL GOVERNMENT. THE ADMINISTRATION HAS INDICATED THAT STATES WOULD BE GIVEN ADDED FLEXIBILITY UNDER FEDERAL LAW TO REDUCE ELIGIBILITY. ONLY SPENDING CAN BE CAPPED--
NOT THE NEEDS FOR HEALTH CARE SERVICES. WHERE SERVICES ARE NEEDED, COUNTIES HAVE OBLIGATIC AND RESPONSIBILITIES TO PROVIDE THEM. WHERE COUNTIES DO NOT HAVE RESOURCES, SERVICES WILL HAVE TO BE REDUCED OR ELIMINATED. EVEN WITH ADDED FLEXIBILITY, STATES CAN NOT MAKE THE MASSIVE LEGISLATIVE AND PROGRAM CHANGES WHICH WILL BE REQUIRED UNDER 50 STATE LAWS IN THE REMAINING MONTHS AFTER FEDERAL LEGISLATION IS PASSED IN FISCAL 1982 TO IMPLEMENT THEM.

WE URGE YOU TO FUND MEDICAID AT ORIGINALLY PROJECTED LEVELS, OF $18.2 BILLION RATHER THAN AT THE LEVEL PROPOSED BY THIS ADMINISTRATION. THAT WOULD REPRESENT A 10.5% INCREASE OVER PROJECTED FISCAL 1981 LEVELS—AND SIGNIFICANTLY LESS THAN THE 15% SPENDING INCREASES IN MEDICAID IN PRIOR YEARS. WE WILL BE MAKING PROPOSALS TO THE AUTHORIZING COMMITTEES, WHICH WOULD EFFECT SUBSTANTIAL SAVINGS IN MEDICAID AND MEDICARE IN FISCAL 1982, NOT REQUIRE A SHIFTING OF COSTS AND NOT HAVE AN ADVERSE IMPACT ON CLIENTS. WE WILL ALSO BE URGING THE IMPLEMENTATION OF MEASURES WHICH COULD BE IMPLEMENTED IN FISCAL 1982, BUT WOULD TAKE LONGER TO PRODUCE DESIRED LEVELS OF SAVINGS.

AS FOR HEALTH PLANNING, THE ADMINISTRATION PROPOSES TO PHASE OUT HEALTH PLANNING AND RECOMMENDS DEEP CUTS. WE HAVE CONCERNS WITH THE CURRENT STRUCTURE OF THE HEALTH PLANNING SYSTEM, BUT DO NOT SUPPORT THE VIEW THAT THE ENTIRE SYSTEM OUGHT TO BE DISMANTLED. HEALTH PLANNING WILL BE A NECESSARY ADJUNCT TO THE HEALTH BLOCK GRANT APPROACH. INSTEAD, WE SUGGEST THAT FUNDING FOR THIS PROGRAM BE CUT COMMENSURATE WITH CUTS THAT WILL BE MADE IN OTHER HEALTH PROGRAMS TO BE CONSOLIDATED INTO A BLOCK GRANT. THER CURRENT STRUCTURE COULD BE RETAINED INTACT THROUGH FISCAL 1982, UNDER THE BLOCK GRANT PROPOSAL, WHILE PROVIDING FOR AN ORDERLY TRANSFER OF HEALTH PLANNING FUNCTIONS TO STATE AND LOCAL GOVERNMENTS.

WE APPRECIATE THIS OPPORTUNITY TO TESTIFY BEFORE YOUR SUBCOMMITTEE AND LOOK FORWARD TO ANSWERING ANY QUESTIONS YOU MIGHT HAVE.

STATEMENT OF RUTH E. KOBELL

I am Ruth E. Kobell, Legislative Assistant for the National Farmers Union, 1012 Fourteenth Street, N. W., Washington, D. C.

I am happy to appear before your Committee today in support of the Senior Community Service Employment Program, Title V of the Older Americans Act, the week following National Older Worker Week. Today, I would like to review some of the history of this program which, I believe, has made an important contribution to the recognition of the value of using the skills, experience, and commitment of our senior citizens to strengthening our national economy.

National Farmers Union is an organization of farm families which began in Texas in 1902. At that time, more than 90 percent of the population of this country lived on farms and used the skills and energy of all members of the family to produce food for themselves and for about five other people in our country. Through two world wars and a great depression, the pattern of farming in the United States underwent a revolution. Machines were developed to do the work of animal and man power, and farms grew larger to support the purchase of machines. By the end of World War II, large numbers of farm people had left the land and moved into the cities.

Part of the people who were forced off the farms moved to the small towns and found limited economic opportunities.

National Farmers Union was concerned about what had happened to this massive displacement of people in this revolution in agriculture, and early in the 1960's established a commission to study rural poverty. It was out of this study and concern that the proposal was made to establish an employment program to demonstrate the ways in which the skills and experience of older people in rural communities could be used to both enhance their limited income and provide vital services to their communities. The report of that commission entitled "Pockets of Poverty" is an important part of the research on rural America.

In 1965, National Farmers Union requested funds to set up the demonstration employment program called Green Thumb to work on highway beautification, parks, and other conservation programs in four states. There were 280 workers involved. We are proud that with the continuing commitment and support from Congress over the years, this program has now grown so that we are able to provide employment opportunities to nearly 21,000 rural older women and men who provide a wide variety of needed services to their communities that would not otherwise be available. Today, we operate projects in 45 states, Puerto Rico, and the District of Columbia, and have expanded the kinds of projects far beyond the original implication of the name Green Thumb.

A year ago, retiring National Farmers Union President Tony Dechant, who had provided support and leadership in Congress for the Green Thumb program, challenged Green Thumb to make food and energy a priority concern. They have attempted to do this.

Green Thumb crews have renovated and weatherized homes of elderly and economically disadvantaged rural citizens since they secured special permission to do so in 1975 and are stepping up their efforts in this area of activity.

We testified a year ago to the Senate Agriculture Subcommittee on Rural Development concerning the operation of federal weatherization programs, and I am attaching a copy of the report on Green Thumb Weatherization Activities of a year earlier to give you some idea of the important contribution to energy conservation which this effort provides.

We have also worked to help with the transportation problems facing many rural residents where public transportation is often nonexistent, and increased energy costs compound the problems presented by weather and roads.

The "Red Cross Dial-a-Bus Service" in Appleton, Wisconsin, which is assisted by Green Thumb workers, demonstrates another aspect of energy conservation. Attached is a report of their work.

Green Thumb workers are heavily involved in projects that relate not only to energy conservation but also to alternative energy production. Fully 15 percent of the workers are involved in projects dealing with the energy problem.

A newspaper reporter, writing in a Butte, Montana, newspaper several years ago said that Green Thumb didn't plant trees, it nurtured lives.

I am attaching to this statement a copy of the quarterly report that is filed with the Department of Labor. This outlines the profile of the workers themselves and the kinds of service in which they are involved. It is a dramatic statistical profile of the Green Thumb program which many of you have followed and supported over the years. You will note that 59 percent are female, 49 percent have an 8th grade education or less, 10 percent are veterans, 15 percent are black, and 7 percent come from other minority groups. Workers aged 70 years and over make up 31 percent of the Green Thumb labor force and, of course, 88 percent of the workers have incomes below the poverty level, even though the eligibility guidelines were increased in Title V of the 1978 Older Americans Act Amendments to 125 percent of the poverty level.

We are also assembling the history of the 15-year-old Green Thumb program which we think you will find interesting. I look forward to presenting a copy to you later this Spring.

The Senior Community Service Employment Program was originally authorized under the Mainstream Program of the Economic Opportunity Act and later became Title IX of the Older Americans Act. With enactment of the 1978 Amendments to the Older Americans Act, it was renumbered to Title V. The outline of the program has continued the same since its inception: Workers must be 55 years of age or older, economically disadvantaged, and have poor employment opportunity. Program sponsors provide at least 10 percent of the cost of project in supplies and supervision of financial support. The projects for eligible individuals must be in services related to publicly owned and operated facilities, or projects sponsored by non-profit organizations which will contribute to the general welfare of the community.

The FY 1981 appropriations passed by the House of Representatives, and included in the Continuing Resolution P.L. 96-536, funds the program at $277.1 million to provide jobs for 54,200 people. Eight national organizations, including Green Thumb, and state governors receive the money to develop projects which provide employment for older men and women. These funds will provide support for the program year, starting July 1, 1981. We hope that Congress will provide funds for the full program year through June 30, 1982.

There is much discussion these days of the cost-benefit ratio in programs funded by the federal government. We believe Title V is an outstanding example of a cost-effective expenditure of federal funds. The program is targeted at the oldest and most disadvantaged, many of whom now receive income transfer payments from Food Stamps, Supplemental Security Income, and other programs. When they come to work for Green Thumb, most often those services are discontinued.

Many Green Thumb workers did not have an opportunity to earn full Social Security coverage for themselves. The opportunity to work provides them the chance to expand coverage under the program. They pay into Social Security and to other federal taxes so that each month Green Thumb remits over $1 million in tax payments for its employees and its contribution as an employer.

Green Thumb workers do those things that would not otherwise be done and therefore add to the Gross National Product in a demonstration of increased productivity. I am attaching to my statement some examples of projects developed by Green Thumb workers. I call your attention to one in New York which renovated an old grist mill, turned it into a neighborhood center, and then installed a solar collector. Today, "the non-profit, community-owned facility -- Glovers Mill Energy Center -- survives by proceeds from sales of pulverized glass, cookbooks, garage sales, memberships," and it serves as a recycling center for the community.

The American Association of Retired Persons/National Retired Teachers Association sponsored an evaluation of the Senior Community Service Employment Program to study the cost-benefit ratio of the program and issued their report February 15, 1978. This project was carried out by Thomas C. Borzilleri, Senior Staff Economist of AARP/NRTA. I would like to quote from Page 6 of this report:

> "At the time of enrollment, approximately 29 percent of the new enrollees were receiving Food Stamps, with an average subsidy or bonus amount of $48.00 per month. The S. S. I. program was paying an average of $65.00 per month to 16 percent of the new enrollees at enrollment.
>
> "Given the wage rate paid by S.C.S.E.P., all benefits from these two programs would be lost by enrollees upon joining the program. Therefore, on average, the Food Stamp and S.S.I. programs save $24 a month (.29 x $48 + .16 x $65) whenever S.C.S.E.P. adds a person to its rolls, and the programs continue to save this amount for as long as enrollees stay in S.C.S.E.P. or remain employed once placed in permanent jobs.
>
> "It was found that, on average, new enrollees had not held a job for 2.2 years; that 50 percent of the enrollees had been unemployed for at least a year; and that 28 percent had been jobless for more than two years. On the last job held prior to employment, the average wage earned was $2.54, with 50 percent of the new enrollees earning less than $2.30."

I understand this report is being updated. I'm sure it will be shared with you once it is completed.

We have estimated that some 8 million people are probably eligible for the Title V program. Clearly, many of them might not be able to work, but there is a long waiting list of applicants at all our projects, attesting to the interest of older people in supplementing their income and using their skills and experience.

It is estimated that unemployment for persons 55 or older are increased by almost 29 percent from March 1980 to July 1980, or from 410,000 to 528,000 in a three-month period. More and more older people are forced into poverty because of the impact of double digit inflation on limited incomes. Older single women represent over 70 percent of those moving into poverty.

There is little opportunity for many of these people to gain employment in the private sector because of age discrimination, in spite of the Age Discrimination in Employment Act. Although part of the emphasis of the Title V program provides help for participants to move into private employment, the continuation of high unemployment makes it difficult for many of them to succeed in this effort.

The severe cutbacks proposed for CETA will further affect the opportunities for older people to demonstrate their employability. CETA has not had a demonstrated record of serving older workers in any event.

Proposed cutbacks in a wide variety of federally-funded programs which provide services for citizens of rural communities will put a heavy burden on local governments to continue to serve the disadvantaged in their population. Green Thumb workers are a welcome addition to help in service delivery in many rural communities. The community projects are developed directly with the local government officials to meet their community needs and the wages paid to the Green Thumb workers from their communities are spent on Main Street to support their local small businessmen.

Because of these many pressures for help, and the cost effective impact of this program on the workers, their families, and their communities, we urge this Committee to continue to support Green Thumb and the Senior Community Service Employment Program as they have in the past which has provided for the growth of the program over the past 15 years to meet the continuing need of both local communities and older workers.

Thank you for the opportunity to appear before you today. We are always happy to report to you about one of the most successful programs which you have supported.

GREEN THUMB WEATHERIZATION ACTIVITIES

(Between July 1, 1978 to June 30, 1979)

STATE	No. Manhours per home with Average Cost	No. homes winterized in past 12 months	Average Cost per house for materials	No. CAP Agencies coordinating efforts with Green Thumb	No. FmHA Agencies coordinating efforts with Green Thumb
Arkansas	24	404	$208.00	10	2
Alabama	24	132	46.00	2	-
Louisiana	24	538	227.00	10	-
Mississippi	24	77	190.00	4	2
Tennessee	24	118	217.00	3	-
South Dakota	40	150	400.00	6	2
North Dakota	40	25	280.00	11	6
Montana	36	108	450.00	2	-
Nebraska	18	6	-	3	-
Wyoming	24	25	550.00	7	2
Kansas	30	26	450.00	-	6
Washington	68	36	186.00	1	-
Oregon	68	416	186.00	6	-
California	48	80	350.00	1	-
Wisconsin	64	165	155.50	3	1
Michigan	53	12	43.00	3	4
Minnesota	96	128	190.00	9	-
Massachusetts	24	2	200.00	1	-
New Hampshire	-	-	-	-	-
Connecticut	-	-	-	-	-
Maine	120	15	460.00	1	-
Vermont	-	-	-	-	-
Kentucky	72	160	350.00	5	4
West Virginia	-	-	-	-	-
District of Columbia	40	12	250.00	1	-
Indiana	24	394	300.00	3	7
New York	37	55	182.00	9	4
New Jersey	75	563	300.00	12	13
Pennsylvania	96	328	320.00	14	-
Maryland	-	-	-	-	-
Ohio	57	152	118.00	7	-
Virginia	20.4	323	250.00	4	-
Florida	40	80	260.00	17	
Georgia	54	40	382.00	3	-
North Carolina	37	32	102.85	3	-
Puerto Rico	30	58	195.00	13	4
South Carolina	-	-	-	-	-
Oklahoma	52	714	275.00	11	-
Arizona	-	-	-	-	-
Nevada	-	-	-	-	-
Texas	42	439	148.00	40	-
Idaho	-	-	-	-	-
Utah	60	12	525.00	6	-
Colorado	70	175	300.00	26	-
Iowa	120	210	250.00	4	-
Illinois	96	107	366.00	1	-
Missouri	63	600	400.00	5	2
TOTAL	53-Average	5,997	$260.69-Average	267	66

$1,685,100.15
per year for materials

Green Thumb, Inc.
Washington, D.C.
October 19, 1979

"THE RED CROSS DIAL-A-BUS SERVICE"

The Red Cross Dial-A-Bus, located in Appleton, Wisconsin employs 16 persons and boasts of having four Green Thumbers. The Dial-A-Bus services the elderly and handicapped of Outagamie County. They provide 5,000 rides a month for work, medical, nutrition, shopping, and social activities.

Will Falk drives a station wagon Monday, Tuesday, and Wednesday. Clarence Thurber drives a station wagon on Wednesday, Thursday, and Friday. Both men are very good about assisting anyone who needs help, and are also rather handsome, so they are quite popular with the older ladies. Drivers fill out daily work records for government and funding sources.

Clara Flanigan, still going strong at age 76, works in the office on Monday through Thursday mornings. She compiles the statistics concerning the rides. This is an exacting job as the number of rides, whether elderly or handicapped, purpose of ride, and mileage per vehicle must be recorded daily. From this a monthly report is figured. She also delivers hot meals to elderly housing units in Appleton and Kimberly on her way home from the office.

Naomi Pilgreen is also in the office. She answers the phone, enters ride requests on the daily worksheets, and answers radio calls from the drivers when a problem arises. She also assists in keeping a card file on all riders up to date. Her work schedule is Monday through Thursday mornings and Friday afternoon.

Crystal Justice, Transportation Coordinator, says she is grateful to Green Thumb for making these persons available to help with a needed and rewarding service. The quality of the employees Green Thumb has provided to Dial-A-Bus is top notch and has stabilized our work climate with their reliability, care, and good humor. Crystal credits the older employee with setting a good example for the younger employees. Kaylene Lezdins, Green Thumb District Director, works closely with Crystal Justice in keeping everyone happy.

OMB Approval No. 44-R1408

U.S. DEPARTMENT OF LABOR • Employment & Training Administration

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM - QUARTERLY PROGRESS REPORT

PROJECT SPONSOR Green Thumb, Inc.	REPORT PERIOD ENDING (Month & Year) December 31, 1980	PROGRAM NO. 41
CITY AND STATE Washington, D.C. (Summary)		TYPE OF REPORT (Check One) ☒ Interim ☐ Final

AGREEMENT NUMBER 99-0-093-11-52	SUBPROJECT NO. 00	PROJECT PERIOD From July 1, 1980	To June 30, 1981
NO. ENROLLMENT POSITIONS ESTABLISHED ➤ ➤	16053	UNSUBSIDIZED PLACEMENT GOAL ➤ ➤	2405

A. ENROLLMENT LEVELS (Number of Enrollees)

1. Carried over from previous project	17071	3. Placed in unsubsidized employment this project	3a 365	3b 533 1/	5. Current enrollment (End of Period)	16982
2. Started under this project	1901	4. Other terminations this project	1625		6. Enrollment vacancies (End of Period)	0

B. JOB INVENTORY

SERVICES TO GENERAL COMMUNITY	NO. JOBS	SERVICES TO ELDERLY COMMUNITY	NO. JOBS
1. Education	2791	11. Project Administration	411
2. Health and Hospitals	702	12. Health and Home Care	531
3. Housing/Home Rehabilitation	351	13. Housing/Home Rehabilitation	936
4. Employment Assistance	203	14. Employment Assistance	95
5. Recreation, Parks, and Forests	1324	15. Recreation/Senior Centers	994
6. Environmental Quality	547	16. Nutrition Programs	2494
7. Public Works and Transportation	1658	17. Transportation	378
8. Social Services	1157	18. Outreach/Referral	1401
9. Other	670	19. Other	139
10. TOTAL (1 - 9)	9603	20. TOTAL (11 - 19)	7379

C. ENROLLEE CHARACTERISTICS

	CHARACTERISTICS	STARTS (Cum.)	CUR. ENROLL.		CHARACTERISTICS	STARTS (Cum.)	CUR. ENROLL.
SEX	Male	825	6830	RACE/ETHNIC GROUP	White (not Hispanic)	1551	13250
	Female	1076	10152		Black (not Hispanic)	190	2540
EDUCATION	8th & Under	759	8234		Hispanic	112	630
	9th - 11th	429	3613		American Indian/ or Alaskan Native	42	505
	High School Grad or Equivalent	515	3857		Asian or Pacific Islander	6	57
	1 - 3 years College	146	1023	AGE	55 - 59	488	2458
	4 yrs. College or more	52	255		60 - 64	560	4332
Family Income at/below Poverty Level		1392	14924		65 - 69	450	4900
Veteran		309	1559		70 - 74	267	3211
D. AVERAGE HOURLY WAGE/CURRENT ENROLLMENT		$ 3.15			75 and Over	136	2081

E. NARRATIVE REPORT (Attachment)	SIGNATURE	DATE

(Formerly MA 5-140) ETA 5140 (Rev. May 1978)

1/ Persons placed in supplement jobs but not terminated from program.

GREEN THUMBERS RESTORE AND REVITALIZE RELIC OF THE PAST

With her figure lines bent, her eyes shuttered, her limbs askew, and her cavernous stomach cobwebby from disuse, how could anyone with 20/20 vision in his wildest imagination consider the derelict on the landscape as being beautiful? Fortunately for everyone in the East Randolph area, near Salamanca, NY, beauty apparently was in the eyes of these beholders: Four Green Thumbers and the director of their host agency in Cattaraugus County.

The alleged "beauty" was in the form of a 150-year-old grist mill called Glover's Mill which at one time ground tons of grain into flour for nearby farmers. In recent times, however, the Mill had fallen victim to more modern and less costly methods.

But to Foreperson Kenneth Wheaton and his fellow Green Thumbers, Herman Marsh, Newton Snow, and Donovan Wetmore as well as to Merle Sheffield, a retired West Point physics instructor and director of Glover's, the Mill had possibilities. They saw things no one else even dreamed possible. They envisioned a structure with new white paint, serving as an energy center for the public. That was in 1977.

To recycle the Mill into usefulness, the dreamers threw energy and perspiration into a work schedule of creating a renewable energy resource. They winched heavy dislodged wooden beams back into position. They built wooden floors for each level of the Mill, constructing stairways to replace the step-ladders of another era. They added a cement basement floor. They laid a 15-inch pipe from a 12-acre pond nearby to capture the overflowing waters, to power a small turbine for the 12 lightbulbs in the Mill.

Second-hand lumber was fashioned by the Green Thumbers into a solar energy collector. Fiberglass covered 1,000 beer cans painted black. The solar panel supplements heat from a wood stove for a major room. However, the "piece de resistance" was the pulverizing and selling of 30 tons annually of crushed glass bottles, metal cans and waste paper. Foreperson Wheaton, a tinkerer from way back, came up with a crusher and a small metal grain elevator, all powered by a recycled chevrolet 6-cylinder engine that carried the residue through the Mill's elevator and down to storage in the old grain bins. Later, county recycling trucks picked up the product.

Today, Glover's Mill Energy Center is a non-profit, community-owned facility, which survives by proceeds from sale of pulverized glass, cookbooks, garage sales, and memberships. But more importantly, it energetically stalks funds and chases foundations and government grants to keep the wolf away from the door.

Glover's Mill is an example of how America might obtain alternate energy sources, and at the same time provide a showcase for the skills of New York Green Thumbers.

STATEMENT OF SYDNEY HOWE

Mr. Chairman and members of the Subcommittee, I am Sydney Howe, Executive Director of the Human Environment Center. Thank you for this opportunity to testify on the FY 1982 appropriation for the Young Adult Conservation Corps (YACC).

Our organization was formed in 1976 to help urban, social equity and environmental interests mount joint efforts toward common goals. One of the most compelling common aims of those interests is served when people go to work in an economically sound employment and service program that protects environments and sustains natural resource productivity. YACC is such a program, according to the considerable information we have analyzed in six months of studying its organization, functions, funding and output.

I attach to my testimony a recent joint appeal by 28 national environmental and human-resources organizations seeking to save and improve YACC. I think you will find this impressive support for the Corps. We, and these organizations, respectfully urge you to reverse the FY 1981 deferral of $58 million from YACC. This loss is already devastating operations and morale in YACC.

More important than these groups' view of YACC, however, are the facts of its performance today and its unique suitability for low-cost service to drastically under-funded public agencies, to the land we live on, and to American youth. It would be absolute pound-foolishness to discard this program in a rash of budget-cutting. YACC is making money!

Much land management work is inevitably labor-intensive. By OMB-approved standards, the 16 to 23 year-old men and women of the Corps are typically found to produce more labor-intensive service for each dollar spent on them than their sponsoring agencies could procure from any alternative investment. Unless you propose simply to stop maintenance in already degraded national parks, and to disregard protection and productivity on wildlife refuges, national forests and public lands, the YACC dollar logically should be sustained until the Federal land agencies are virtually wiped out.

I know we have an anomaly here, for you are looking at a Labor Department employment appropriation. YACC is an employment program, too, and 40% of its enrollees are economically disadvantaged. The benefits just cited do not begin to encompass the welfare costs thus avoided or the new confidence and training that lift so many YACC youths into employable status after their Corps experience.

But I hope, most of all, that you will view the Young Adult Conservation Corps as a service, and that you will not have undue concern just now for its administrative arrangements. It is a service program, akin to the highly bipartisan CCC that succored its members and the Nation's self-respect in the 1930s. It gives unemployed and footloose young people a chance to pay their way while finding their bearings. It is appreciated intensely by every Federal bureau it serves, and by the states and communities where the non-Federal 30% of its funds support YACC crews. The Corps is increasingly serving to rehabilitate urban and community facilities, as in the South Bronx, New York City, San Francisco, Washington, D.C., Denver, Boston and Chicago.

YACC crews are performing many kinds of traditional conservation work and they are conserving energy, restoring dilapidated parks, combatting pest infestations, creating gardens in cities, and planting urban and forest trees. In many urban settings, these young people lift both the face and the spirit of their members' own neighborhoods. And how important that sense of accomplishment and belonging is, in this time of alienated, languishing youth!

As you might imagine, we think Federal funding for YACC should be going up, not down. We think there are ways to improve the Corps, to make it serve more of the jobless, to involve private enterprise and organized labor more positively in its functions, and to increase its development of employable skills. There might even be private cost-sharing for woodlot improvement, erosion control and other public-private benefits from future youth work on private lands.

Before those potentials can be weighed seriously, however, the basic YACC program must be sustained. To dismantle the YACC system of trained supervisory personnel, operating facilities and equipment now would be to disable an infrastructure that is working, for our youth, cities and countryside.

We ask that you appropriate at least $275 million to support the Young Adult Conservation Corps in FY 1982. This would, in current dollars, match the FY 1980 appropriation of $250 million.

Again, thank you for hearing our request and concerns. Attached to my statement is an impressive list of YACC 1979 work accomplishments and a February 23 letter to the President, pointing out sharp contrast between YACC information from the White House and that from Federal departments. We hope you will find out why such conflicting representations are given to the public. I shall be glad to answer any questions you may have or to submit further documentation.

February 19, 1981

HALT THE DEFERRAL OF 1981 YACC FUNDS

The undersigned organizations urge that the current deferral of $58 million in FY 1981 Labor Department funds for the Young Adult Conservation Corps be reversed by either Senate or House action before March 1, 1981, or by the new Administration.

The deferral is now disrupting YACC operations in the Departments of Interior and Agriculture and other federal agencies, and in state and local youth programs. Although we do not necessarily support all policies governing YACC, we believe it is demonstrating economically efficient means of serving major national needs of our youth and of our urban and rural environments.

This program should be improved, not cut.

American Association of Small Cities
ASPIRA - Center for Educational Equity
Center for Community Change
Center for Urban Environmental Studies
Environmental Action
Environmentalists for Full Employment
Friends of the Earth
General Federation of Women's Clubs
Human Environment Center
Institute for Local Self Reliance
Izaak Walton League of America
National Association of Civilian Conservation Corps Alumni
National Association of Counties
National Association of State Conservation Corps Program Agents
National Audubon Society
National Council of La Raza
National Parks and Conservation Association
National Puerto Rican Coalition
National Recreation and Park Association
National Urban Coalition
National Urban League
National Wildlife Federation
National Youth Work Alliance
Native American Rights Fund
Preservation Action
Sierra Club
Urban Environment Conference
Wildlife Society

Coordinated by:

Human Environment Center
(Formerly Urban Environment Foundation)
1302 - 18th Street, N.W.
Washington, D.C. 20036
202/466-6040

Contact: Janice Carmichael

February 23, 1981

The President
The White House
Washington, DC 20500

Dear Mr. President:

Someone in your employ is seriously misleading you and/or the public.

On pages 6-29 and 6-30 of "America's New Beginning: A Program for Economic Recovery," the February 18 Budget document, there is a series of findings about the Young Adult Conservation Corps (YACC) which contradict or ignore facts in reports and other communications we have received recently from the Office of Youth Programs in the Department of Labor (376-2646), the Office of Youth Programs in the Department of the Interior (343-5951), and the Human Resource Programs Office of the Department of Agriculture (447-9801).

Acknowledging your determination to reduce Federal expenditures, we have every confidence that you stand for accuracy and truth. But Sir, either your White House staff is issuing inaccurate and grossly misleading information about YACC, or the offices cited above are themselves issuing false and misleading information directly to the public.

Aside from contradicting your Departments, for example, as to the portion of YACC participants who are disadvantaged, the Budget document disregards Labor, Interior and Agriculture statements that YACC is typically cost-efficient in conservation work alone. If information given us by bureaus operating YACC crews is accurate, the Budget's termination of this program would halt the Nation's lowest-cost work for essential park protection and resource productivity -- just when regular agency budgets are being cut!

Please investigate the facts of YACC as a natural resource program which, we have been informed, additionally provides youth employment and training benefits, in cost-efficient "workfare, not welfare."

Yours respectfully,

Sydney Howe

Sydney Howe
Executive Director

From: Youth-conservation Employment
Human Environment Center
November 1980

Attachment

YACC 1979 WORK ACCOMPLISHMENTS

The following information, on pages 16 and 17, describes work performed by YACC enrollees in Fiscal Year 1979. This material has been copied from the U.S. Department of Labor, ETA/Office of Youth Programs, "Joint Annual Report to the President and Congress, Young Adult Conservation Corps," Washington, D.C., 1979, unpublished.

Department of Agriculture:

	Units	Quantity Accomplished	Appraised Value of Accomplished Work
Timber Stand Improvement	Acres	49,090	$ 5,555,728
Reforestation	Acres	47,996.5	4,462,722
Other TM Activities Including TM Research	Person Days	72,206	3,010,847
Litter Pick-up Rec. Areas	Person Days	36,340	1,563,055
Visitor Assistance	R.V.D.	531,786	736,402
All Trail Construction	Miles	182,791.2	3,370,182
All Trail Maintenance	Miles	1,237,958.3	5,210,082
Litter Pick-up Roadsides, Trails, and Streams	Person Days	1,489,549.5	1,000,849
All Recreation Development	R.V.D.	8,264,401	12,532,721
All Engineering	Project	2,570	9,133,346
Range Revegetation	Acres	50,820	647,368
Range Fence Construction	Linear feet	2,924,775	2,825,128
Other Range Management Activities	Person Days	31,558	2,412,229
Fish & Wildlife Direct Habitat Improvement	Acres	147,419	4,087,113
Other Fish & Wildlife Management Activities Including Research	Person Days	21,088	1,125,883
Direct Erosion Control	Acres	17,994.5	1,616,528
Pollution Abatement	Projects	5,086	763,985
All VIS Construction, and Preparation of Brochures, etc.	Person Days	58,251	387,149
Minerals Management	Cases	117	94,593
Forest Fire Management & Protection	Acres	216,870.6	6,717,210
Special Use Administration	Miles	1,773.3	329,696
Land Line Location	Miles	1,098.15	1,131,930
Corner Search	Corners	765	342,566
Other	Person Days	430,361	15,112,653
Construction Development and Maintenance of YACC Facilities	Person Days	79,253	5,890,273
Total Value			$90,060,238

Department of the Interior:

The Department of the Interior valued work of YACC enrollees on natural resource projects at $82,016,397 during Fiscal Year 1979. Some major selected work accomplishments of YACC in Fiscal Year 1979 were:

16,327	Acres of trees were planted
29,063	Acres of timber stand were improved
4,203,000	Visitors to public facilities were assisted
7,375	Acres of land benefited from soil erosion control projects
320.2	Miles of new trails were constructed
1,037,950	Acres received wildlife habitat improvements
333,934	Enrollee hours were used on YACC camp construction and maintenance projects
290	Projects that related to surrounding communities

State and Local:

Resource Category	Approximate Value of Work
Timber Management	$ 6,042,623
Recreation Development and Maintenance	17,211,912
Visitors Service	7,100,014
Range Management	775,828
Fish & Wildlife Habitat Improvement	2,922,844
Engineering and Construction	6,464,500
Water and Soil Conservation	2,728,201
Community Land & Water Projects	11,088,824
Total	$54,334,746

The Departments of Agriculture and Interior and state and local YACC officials state that the program accomplishes work that would not otherwise be done, and does not "displace currently employed workers, impair existing contracts, or result in the substitution of YACC for other funds in connection with work that would otherwise be performed."

HEALTH SERVICES ADMINISTRATION

Senator SCHMITT. The next panel, dealing with the Health Services Administration, is as follows, and if they'll come forward, we'll save a little bit of time.

David Gad-Harf, executive director, National Rural Primary Care Association; Cathy Schoen, staff economist, Service Employees International Union; Faye Wattleton, president of Planned Parenthood-World Population; Dr. H. Carl Haywood, president of the National Association of Mental Retardation Research Centers, joined by Dr. Herbert Cohen, Clyde E. Shorey, Jr., vice president of Public Affairs, March of Dimes Birth Defects Foundation; Dr. Naomi L. C. Luban, associate director of the Hematology/Blood Bank, Children's Hospital, National Medical Center; Mike Gorman, executive director of the Citizens for Treatment of High Blood Pressure, Inc.; and Tom Van Coverden—I believe that's been canceled. Your prepared statements will be printed in their entirety after your oral presentations.

STATEMENT OF FAYE WATTLETON, PLANNED PARENTHOOD WORLD POPULATION

Senator SCHMITT. If the rest of the panel would not object, I would ask Faye Wattleton to be first. I understand that she has another appointment very shortly, and we'll try to accommodate her.

Ms. Wattleton?

Ms. WATTLETON. I am Faye Wattleton, president of Planned Parenthood Federation of America. On behalf of the organization, representing 187 community-based affiliates, I am here to urge strong support of the national family planning program through title X of the Public Health Service Act.

Mr. Chairman, our present economic and political climate dictates every program in the entire Federal budget be carefully scrutinized to determine, first, whether the issues in the program address the immediate and important national goals we face; and whether those programs advance us toward a goal in an efficient and cost-effective manner.

We believe Congress has recognized the magnitude and severity of the problems associated with unwanted pregnancies and has acknowledged that the national family planning program does, in fact, address this major national issue, and does so in a cost-efficient manner, and that it does so in a way that meets the urgencies of the needs, and we urge the committee to consider approving funding levels as a direct result of the federally subsidized program.

We have seen the elimination of the historic differences between the affluent and the poor in access to family planning services.

The Congress, and this subcommitte in particular, have traditionally demonstrated its understanding and compassion for supporting programs that enhance the lives of Americans.

Senator SCHMITT. I will have to ask you to wrap it up.

Ms. WATTLETON. OK.

In this year's budget decisions, unquestionably the issue is cost effectiveness. And by this analysis, title X is exemplary.

The average cost of providing services is approximately $90 per year. And for each $1 that is invested, $1.80 is returned.

We, therefore, recommend that family planning services receive an appropriation of $190 million, which is appropriately adjusted for inflation at this year's budget; and for research we recommend $1 million to permit additional advances in this area.

We recognize the controversy that frequently surrounds family planning. But, we do believe that it is the key to preventing the need for many of the abortion services that we recognize. And the public recognizes this and Congress has recognized this for many years.

Surely the prevention demands no less passion and support than we have demonstrated in the past.

Thank you.

Senator SCHMITT. Thank you very much.

Mr. David Gad-Harf, executive director, National Rural Primary Care Association.

STATEMENT OF DAVID GAD-HARF, EXECUTIVE DIRECTOR, NATIONAL RURAL PRIMARY CARE ASSOCIATION

Mr. GAD-HARF. Chairman Schmitt, I really appreciate the opportunity to appear before you today. NRPCA is an organization representing over 700 rural community health programs across our Nation. I want to express our support of the administration and Congress in their efforts to restrain Government spending, elimination of waste, inefficiencies, and ineffectiveness.

At the same time I also want to lend our strongest support to our national commitment to addressing the essential health care needs of our most deprived citizens. It was just 1 week ago today that the chairman stressed these objectives within his speech to NRPCA's National Conference on Rural Primary Care.

I will briefly discuss this morning four Federal initiatives that together constitute this Nation's major rural health development effort: Community health centers, migrant health centers, primary care research demonstration, National Health Service Corps programs.

The community and migrant health centers programs were established to help meet the basic health needs of rural and other citizens living in economically depressed areas. NRPCA believes that through continued emphasis on achieving greater efficiency in the management of health centers, in combination with the support they have gained from their communities and States, existing centers can continue to be successful at current funding levels.

The primary care research and demonstration program also warrants continued Federal support at its current level. The purpose of this program is to test pragmatic, cost-effective methods to provide primary health care to medically underserved populations.

Finally, in regard to the National Health Service Corps, NRPCA has serious reservations about the administration's projections of much improved position availability for rural areas. Nevertheless, based on our knowledge of the number of students to be placed by 1990, NRPCA supports a substantial reduction in new NHSC scholarships. We strongly endorse the proposal to maintain the NHSC placement program, allowing students who currently have scholarships to complete their training.

Again, I greatly appreciate your consideration of NRPCA's testimony, and will be pleased to provide you with any additional information which might facilitate your review of the rural health programs upon which I have commented today.

Thank you very much.

Senator SCHMITT. Thank you, David.

Next, Cathy Schoen, Service Employees International Union.

STATEMENT OF CATHY SCHOEN, STAFF ECONOMIST, SERVICE EMPLOYEES INTERNATIONAL UNION

Ms. SCHOEN. Thank you.

I am here representing the Service Employees International Union, a union of more than 650,000 workers. And we include workers in community health centers across the country.

Today I am talking on behalf of the community health center program.

As consumers of health care and as health-care workers, we urge you to give strong support to the community and migrant health center program with an appropriation that allows the program to expand and to keep up with the cost of providing services.

We think that community health centers are one of the most vital national resources we have for reaching medically underserved communities and for fighting inflation. Last week we learned that the administration plans to fold this program into a block grant with a 25-percent reduction. This step would both be backward and inflationary.

I'm going to briefly summarize a few facts that we put in our testimony, given the shortage of time here.

In the past 6 years, community health centers have demonstrated that they actually fight health care costs, not add to them. They have shown a 25-percent reduction in hospital days and admissions repeatedly throughout studies that have been done with them.

Recently a study has shown a 6- to 50-percent reduction in Federal and State medicaid dollars from people who use health centers as opposed to similar groups of people who don't have access to them. They are cheaper sources of care.

In 6 years, they brought down the visit costs by 31 percent, and that is in actual dollars. I think it is a phenomenon in the health care industry, actually to have decreased their costs.

All of this has been done with a decline in real Federal dollars of 12 percent over the last 6 years.

We need an expansion in the program to allow for inflation and to reach communities that don't now have access to health centers. To reduce the program now would be to close centers. This would lose jobs in communities and would actually increase the cost of care. People would have to go someplace else and they would probably turn to emergency rooms for hospitals.

In summary, we urge you to expand the program. We put some numbers in our testimony; estimated $400 million would allow for inflation and a 10-percent increase based on the current 1981 appropriations.

Thank you.

Senator SCHMITT. Thank you, Cathy.

Next, Dr. H. Carl Haywood, president, National Association of Mental Retardation Research Centers, American Association of University Affiliated Programs.

STATEMENT OF DR. H. CARL HAYWOOD, PRESIDENT, NATIONAL ASSOCIATION OF MENTAL RETARDATION RESEARCH CENTERS

Dr. HAYWOOD. Thank you, Mr. Chairman.

The best way to save money is to prevent the need for its expenditure. In the area of mental retardation, so much progress has been made through research, that we are now on the threshold of realizing the goal of reducing the incidence of mental retardation by 50 percent by the end of this century.

If we can accomplish that, the saving will be far greater than that accomplished by the budget cuts proposed by the President.

A familiar example is phenylketonuria, PKU, a preventable metabolic disorder that results in serious and lifelong brain damage. Basic research provided the means to detect this metabolic error immediately after birth before the damaging effect on the brain began.

Further research at our research centers demonstrated a completely effective treatment. The Nation's network of 47 university affiliated facilities took these research results to the State. This is an example of a wise way to reduce Federal expenditures for mental retardation through prevention and through the dissemination of knowlege to the State.

Other examples include exciting new work on the prevention of Downe's syndrome without the necessity for abortion; and of fetal alcohol syndrome following work done in these centers.

Prevention, Mr. Chairman, pays. Every case of severe or profound retardation that is not prevented, can cost between $1 and $2 million in medical, social, institutional, and special educational care over the lifetime of the affected person. Every dollar we save now by not financing these programs for research and research utilization, will have to be spent many times over in both the immediate and long-term future on care, treatment, education, and habilitation; services that could have been prevented altogether.

We are urging reauthorization of the Developmental Disabilities Services Act with provision of $7 million in the continuing resolution for fiscal year 1981, and an appropriation of $8 million in fiscal year 1982; continuation of the maternal and child health research and training programs with $30 million in fiscal year 1981, and $33 million for fiscal year 1982; and provision of $225,190,000 in fiscal year 1981, and $235,849,000 in fiscal year 1982 for the National Institute of Child Health and Human Development, of NIH, of that amount, with $6.8 million in fiscal year 1981, and $7.5 million in fiscal year 1982 designated for corps support for the 12 national mental retardation research centers.

We share the view, Mr. Chairman, of Senator Hollings of South Carolina, who said in an article in the Washington Post last week, "It's a lot cheaper to nourish infant brain cells in the womb and during life's early years, than it is a medical special education and welfare cost 5, 15, or 30 years."

We urge you to take this approach to conservation of both economic and human resources.

Senator SCHMITT. Thank you.

Clyde E. Shorey, Jr., vice president, Public Affairs, March of Dimes.

STATEMENT OF CLYDE E. SHOREY, JR., VICE PRESIDENT FOR PUBLIC AFFAIRS, MARCH OF DIMES BIRTH DEFECTS FOUNDATION

Mr. SHOREY. Thank you, Mr. Chairman.

I wish to speak about the funding for the National Genetics Diseases Act, which is one of the parts of the line-item genetic information and counseling.

Actually, the previous speaker has just made my case, because the National Genetics Diseases Act funds the delivery of services for which his research has provided many of the answers.

In the area of metabolic diseases, the tests that are able to be given under the National Genetics Diseases Act can prevent mental retardation, as he said, for PKU, hypothyroidism, galactosemia, and a number of other instances with a cost-benefit ratio which has been determined by several States, the Center of Disease Control, as high as 36 to 1.

The current funding of the genetic disease program allows only 34 States to take part in this program. One of those that doesn't is the State of New Mexico, where Dr. Acey, who is on the staff of the University of New Mexico really hasn't filed an application because of the fact that there are not really sufficient funds to fund any further grants.

I would like to suggest to your committee that a level of funding for genetic diseases should be at $17 million, which is proposed by the original 1982 budget submission. This is out of a total of $20,368,000 for the total line item.

Since I filed my testimony, the administration has proposed a block grant for preventive health services, which would include 11 different areas of services; 1 of which is the genetic services. I would like, if I could, to file a supplemental statement commenting on the level of funding which is included in the administration proposal.

Senator SCHMITT. Thank you.

Next, Dr. Luban, associate director of the hematology/blood bank.

STATEMENT OF DR. NAOMI L. C. LUBAN, ASSOCIATE DIRECTOR, HEMATOLOGY/BLOOD BANK, CHILDREN'S HOSPITAL MEDICAL CENTER

Dr. LUBAN. Mr. Chairman, I am Dr. Naomi Luban, and I am a pediatric hematologist at Children's Hospital National Medical Center in Washington, D.C. I am here on behalf of the National Hemophilia Foundation.

Hemophila, or bleeder's disease, is an inherited condition where blood protein, factor 8, is absent from the blood causing bleeding into any organ of the body, but most especially into joints and muscles.

In 1975, section 1131 of Public Law 9463 was enacted to establish the comprehensive hemophilia diagnosis and treatment center programs. In each of the first 4 years the appropriations committees have funded this program. During the first 3 years, the level was $3 million each year. And last year the level was established at $3.3 million in the continuing resolution.

The authorized levels for the past 3 years were $4, $5, and $6 million.

This legislation is up for reauthorization this year. I would like to tell you how astonishingly successful our program has been in the first 4 years of its life.

There are now 25 core treatment centers, and nearly 50 satellite service programs serving approximately 6,000 hemophiliacs.

Unanticipated and valuable research and health care spinoffs have occurred. Genetic screening, detection and counseling, hepatitis studies, patterns of comprehensive care, financial counseling, and the use of these centers as models for other disease categories requiring comprehensive care, all have been a product of this program multiplying Federal dollar use.

The attached addendum to this testimony will show the remarkable success story in terms of the lives of patients. These include cutting time lost from work and school, and an increase in patients on home care.

A regionalized program has developed wherein hemophiliacs from States without centers receive care in States with centers. Because this program serves a low-density scattered population, it cannot be administered in a State-by-State way without seriously compromising the present efficiencies of scale and the growing number of connections among the hemophilia treatment centers, crippled children services programs, and the Genetics Diseases Act program.

We urge that this program not become part of the block-grant program; or, if it is found necessary to include it, that a legislative variance be written into the law in such a way as to assure continuance of these regionalization patterns.

We recognize that the Appropriations Committee will not write the law authorizing the block-grant program, but it will make the decision of the appropriations regarding block-grant programs, and so we wanted to bring this to your attention.

We request a fiscal year 1982 appropriation of $4.5 million for the comprehensive hemophilia diagnosis and treatment care program.

Inflation and the work yet to be done require an increase from the essential $3 million level of operations for the past 4 years.

Hemophiliacs can now enjoy a nearly normal lifestyle due to breakthroughs in science and the existence of topnotch treatment programs which has translated those breakthroughs into accurate diagnosis, rapid treatment, and comprehensive care.

Senator SCHMITT. Wrap it up, please.

Dr. LUBAN. Therefore, we support the work of the NHLBI, NIAMDD both of which help support research into our disease.

We also support the Coalition for Health Funding figures for fiscal year 1982 at a level of $625 million for NHLBI, including training, and $409.5 million for NIAMDD.

Thank you.

Senator SCHMITT. Thank you.

Mike Gorman, executive director, Citizens for the Treatment of High Blood Pressure.

STATEMENT OF MIKE GORMAN, EXECUTIVE DIRECTOR, CITIZENS FOR TREATMENT OF HIGH BLOOD PRESSURE, INC.

Mr. GORMAN. This is about my 20th appearance here since I left Mr. Truman. I see Gar Kaganowich of the Budget Office. We worked together on Abraham Lincoln. [Laughter.]

I'll be brief on this. I know it is difficult.

I am speaking on behalf of the hypertension project grants for the States. I will not inundate you with figures. You have probably got enough before you for the rest of the day.

I will just make one simple statement; Blue Cross/Blue Shield, after a 2-year study in a number of States concluded in a report of 1980 that high blood pressure is "the most common adult chronic disease."

According to figures from both the Health Services Administration and the National Heart Institute, 60-million Americans have high blood pressure. It is not an exotic disease. High blood pressure is the major factor in three-fourths of all first strokes, and is a major factor in two-thirds of first heart attacks.

I don't want to threaten the members of this committee, but the American Society of Actuaries have just done a recent actuarial study with one interesting fact of many—and we don't have the time to go into it, but at age 35 if you have high blood pressure, 20 diastolics over the normal, you shorten your lifespan by 9 years. As you get older—and you guys are a little older than 35—it gets more threatening. Believe me it is very threatening.

I won't go into the figures on economics, but I want to make an unusual request of you—and I am glad Dr. Luban made the point about the relevance between appropriations and authorizations.

Our board, from Dr. DeBakey on down—Dr. Michael DeBakey is the chairman of our committee—and thousands of physicians are convinced we created the first believable prevention program against a chronic disease. And we have, and we proved it in spades.

Dr. Robert Levy, Director of the National Heart Institute has put it as well as anyone, and I quote from Dr. Levy. Very simple:

> In high blood pressure, our Nation's primary goal is prevention. It is the only truly effective program. In five short years the program has become what it is today perhaps the most exciting program of disease prevention. In that period of time we have witnessed a miraculous drop of 38 percent in stroke deaths, and 25 percent in heart attacks. In other words——

And this ends the quote from Dr. Levy:

> Despite these achievements——

And this is the major thrust of what I want to say in these last couple of minutes:

> We've had a long and hard struggle to maintain our visibility and our connection with the mainstream of American Medicine.

Mr. Chairman, for years we were buried in 314(d), the basket grant to the States which we view as one of the great legislative disasters of all time. Mainly through the efforts of then Senator Schweiker, we got out of 314(d), we were freed and we were on our own for a short while. Now we find ourselves in a block grant with a bunch of Centers for Disease Control programs. Incredible. This really dismays us.

Last year the Carter administration tried its darndest to transfer us to the Centers for Disease Control. We barely managed to escape, and now it looks like another struggle to stay out of these centers, whose track record in prevention—and I'm putting this mildly—has never set the world on fire.

Senator SCHMITT. Would you wrap up, please, Mr. Gorman.

Mr. GORMAN. I know, it is very difficult.

What I'm saying is this—let me get to the end where I'm going to plead with you for mercy.

Senator SCHMITT. You are going to have to plead with all the other people who aren't going to get to testify.

Mr. GORMAN. I understand your difficulties, Mr. Chairman. Don't think I don't.

Mr. Chairman, I realize this is not a legislative committee, but, as Dr. Luban has pointed out you know and I know there is a tremendous impact on the direction which programs take.

May I plead with you and with Senator Rudman and with others—and I have talked about this with Mark Hatfield—the support legislation currently being drafted is a simple amendment to title IV transferring our program to that authority. In other words, to the Public Health Service.

In other words, we want a final home. The present thought is that the legislation could even be more specific. Title IV deals with your authorizations for the National Institutes of Health. Section 414 under the National Heart, Blood, and Blood Institute authority deals with the prevention, control, and education activities of the Institute. In other words, the application of research findings to the prevention of disease. This is where we belong.

We would merely add another section 414 authorizing a 2-year extension of the hypertension grants to the States. And we don't really care about the money right now. We want some money, but I am not going to talk about money. We would like a reauthorization by May 15 for this program.

So that, in essence, is what it is. It is that completion be made.

Senator SCHMITT. Thank you.

Dr. Cohen?

STATEMENT OF DR. HERBERT COHEN

Dr. COHEN. My name is Dr. Cohen.

Senator SCHMITT. 30 seconds I am told is all you need. We really are running out of time and other people want to testify. So, try to make it 30 seconds.

Mr. COHEN. I represent 47 university affiliated programs that Dr. Haywood described some of the research applications of.

We have centers throughout the country. We have several of our directors from South Carolina, from Georgetown and from Florida behind me.

We represent the application of research findings and new technology in the area of treatment, prevention of mental retardation and training of personnel who are used in the $12 million national effort in services for the mentally retarded.

We are clearly one of the most effective operations in the last 15 years in this field, and have provided some of the technology to shorten the time for use of technology in the field from the 5 to 10 years you are aware of, down to a few years in our centers which are often colocated with the mental retardation research centers.

Recently we applied technology in the telecommunications area to the neighboring State of Vermont—Senator Rudman's neighboring State—in bringing mental retardation services to rural areas.

Senator SCHMITT. I'm going to have to ask you to present anything you have to us in writing.

Mr. COHEN. Thank you.

[The statements follow:]

STATEMENT OF FAYE WATTLETON

I am Faye Wattleton, President of the Planned Parenthood Federation of America. On behalf of Planned Parenthood's 187 community-based affiliates providing family planning education, counseling and medical service to about 1.2 million in 43 states and the District of Columbia, I am here today to urge your continued strong support of the national family planning program--through Title X of the Public Health Service Act.

Mr. Chairman, our present economic and political climate dictates that every program in the entire federal budget be carefully scrutinized to determine, first, if it is designed to address an immediate and important national goal and, second, if it is indeed working to advance us toward that goal in a cost-efficient manner. In seeking to reduce both the role and the size of the federal government, it cannot be denied that certain problems do transcend state boundaries and deserve concerted and coordinated national attention.

Congress has recognized the magnitude and severity of the problems associated with unwanted pregnancy, especially among teenagers, and acknowledged the success of the national family planning program in addressing the urgent need for services by historically approving funding levels over and above the president's request. For fiscal year 1981, Congress appropriated small increases over the previous year for a total of $166 million for family planning services and $79.4 million for studies in human reproduction and population at the Center for Population Research (CPR) of the National Institute for Child Health and Human Development (NICHD). Yet, both components of Title X actually suffered reductions in real dollars, and in the absence of any attempt to offset the pressures of inflation by increasing funding, current levels of effort simply cannot be maintained. The Bureau of Community Health Services, which administers Title X services, has indicated that even if funding continues in fiscal year 1982 at the same level as in FY 1981, over 200,000 currently enrolled patients must be turned away because of increased program costs due to inflation. Developments in population research, which benefit all classes of society in the United States and around the world, would also have to be sharply curtailed, with the severest impact falling upon the two areas of study at

CPR that are probably of most vital concern to us all: contraceptive development and contraceptive safety.

The desperate need for subsidized family planning services is glaring: 1.1 million teenagers became pregnant last year, there were 1.5 million abortions (one-third among teenagers), and several hundred thousand married women (a disproportionate number being poor and over 35) had unwanted births. These are but a few of the indicators of the job before us--problems not only large in magnitude but critical in that each woman's life, and that of her family, is changed forever in the event of an unplanned pregnancy and birth. At the same time, the success of the national family planning program is stunning: an NICHD study documented that an estimated 1.4 million unwanted births were averted in one six year period as a direct result of the federally-subsidized program, there has been a marked increase in recent years in the use of the most effective methods of contraception among lower income groups thus eliminating the historic differences in use and choice of method between the poor and the affluent, and because of increased and more consistent use of contraception the pregnancy rate among sexually-active teenagers has been declining.

The Congress, and this subcommittee in particular, has traditionally demonstrated its understanding and compassion by supporting programs enhancing the quality of life for American families. That Title X contributes to this goal through providing a wide array of preventive reproductive health services to 4.5 million poor women and teenagers in nearly every county in the country has never been disputed by the Congress. Screening for cancer (Pap smear, breast examination) and venereal disease is simple and routine at the clinics but might otherwise be neglected until it is too late to intervene with effective treatment. Organized programs have become the nation's largest initial entry point into the health care system for teenagers, who comprise almost one-third of the total organized national family planning caseload.

In this year's budget decisions, unquestionably, the issue is cost-effectiveness and by this analysis Title X is exemplary and unrivaled by any other federal program in its accomplishment. It has been shown to save the government money in a ratio of $1 invested yielding $1.80 in government savings the very next year. It is clear that without the national program in place, government welfare costs would be significantly greater--certainly the human costs would be. The average yearly cost per family planning patient, including not only contraception but also related preventive health services, is extremely low, about $90 in FY 1982. This represents less than the cost of a year's supply of birth control pills provided through the private sector (or reimbursable under Medicaid) not to mention doctors' fees. Family planning providers and administrators have proven a strong and successful commitment to finding highly cost-effective methods of delivering quality care. Mr Chairman, this country cannot afford not to at the very least sustain the current level of services.

In summary, Mr. Chairman, on behalf of Planned Parenthood I strongly urge you to prevent any retrenchment in the dramatic progress we have made in assisting the disadvantaged in avoiding unwanted pregnancies. Even now, for each woman receiving subsidized family planning services there is at least one somewhere else who also needs service but is unable to obtain it. Planned Parenthood recommends for family planning services an appropriation of $190 million which approximately adjusts for inflation. For research, we recommend $100 million to permit CPR to broaden our understanding and pursue promising leads in the areas of biological and behavioral aspects of human reproduction, contraceptive safety assessment, and the development of new and much needed contraceptive methods.

Mr. Chairman, the abortion controversy arouses contradictory passions and fears but there is a general consensus that increasing access to family planning services is the key to preventing and reducing the need for abortion. The public recognizes this; Congress has recognized this in the past and we trust it will continue to do so this year and in the years to come. Surely, prevention demands no less passion and support.

STATEMENT OF DAVID GAD-HARF

I greatly appreciate the opportunity to appear before you today as Executive Director of the National Rural Primary Care Association. NRPCA is an organization representing approximately 700 community programs across our Nation, which currently are providing health care services to citizens in rural areas.

Overall, I am here to express our support of the Administration and Congress in their efforts to cut back government spending and, particularly, to eliminate waste, inefficiences, and ineffectiveness associated with that spending. I am here also to lend our strongest support to our National commitment to assure that Federal policy and programs continue to be directed to meeting the essential health care and other human service needs of our most needy citizens. In that regard, I am confident that Senator Schmitt, along with each member of this Subcommittee, will agree with NRPCA that the programs I shall discuss with you today are integral to meeting that National commitment. These programs are the Community Health Center Program, Migrant Health Center Program, and Primary Care Research and Demonstration Program.

The Community and Migrant Health Center programs were established to meet the basic health needs of rural and other citizens living in economically depressed areas. As you know, our rural populations generally tend to include proportionately more young, more elderly, and more individuals and families than our urban areas. The very nature of the population, then, as well as the nature of their work, places rural citizens at greater health risk than those who live in metropolitan ones. However, consistent with the Administration's criterion that Federal support be directed only to our most needy, only those rural populations which have met Federally established standards of need (Medically Underserved Areas) have been targeted for Community and Migrant Center Projects.

I also would emphasize that the health center programs are not simply two among those various categorical programs which often have been criticized for contributing to fragmented service delivery and other inefficiencies inherent in their administration and implemen-

tation. On the contrary, Community and Migrant Health Centers have been established specifically as mechanisms to bring a broad array of health and social service resources under the administration of one organization. That emphasis has proved cost-effective and has led to the development of innovative methods to make best use of existing resources within a center's service area, contiguous areas, and the State as a whole. In those ways health centers not only have addressed the needs of the most underserved populations, but also have provided otherwise unavailable primary care services to a broad base of rural citizens. Finally, the Centers' emphasis on health maintenance and illness prevention also has been demonstrated to be cost effective, with studies indicating that a population's access to comprehensive primary care services reduces their need for hospital care by as much as 25 per cent.

With respect to funding to help underserved rural areas provide care to large seasonal influxes of migrant workers, the need is also great. The provision of basic health services to this population--including inpatient care--is necessary to the economic well-being of these areas, as well as to maintaining the health of their migrant and resident populations. The economy of these areas often depends on the seasonal workers but is not able to absorb the additional costs of providing services to them and their families. Migrant health centers also play an important role in preventing and controlling health problems associated with camp and field sanitation and other environmental factors.

In summary, the Community and Migrant Health Centers meet the major criteria for continued Federal support as set forth to date by the Administration and as established by Congress through existing National policy. They are aimed at providing essential health services to those who otherwise could not obtain them, they have reduced overall health care costs, both by providing a mechanism to integrate a wide array of fragmented programs into a coherent, continuous system of care and by emphasizing health promotion and illness prevention; and they have in all instances sought to meet the unique needs of specific population groups, with states and communities being significantly involved in establishing service priorities.

Finally, before turning to NRPCA's recommended fiscal 1982 funding level for the Community and Migrant Health Centers, I would note that the existing priorities for disbursement of these project funds focus on maintaining the operations of existing centers, expanding the capacity of those centers to reach more persons within the area they currently serve or contiguous ones, and enhancing the administration and organization of center programs in order to reduce costs through greater efficiency. In a time of less need for fiscal austerity, NRPCA would encourage the expansion of those priorities to include the development of additional centers and broadening the scope of services in existing ones. However, we would go on record today as supporting the existing, more restrictive funding priorities.

As previously cited, the major funding priority must continue to be to maintain the operations of the existing centers. During 1981, 995 Community and Migrant Health Centers will have a capacity estimated to serve over 6.5 million of our medically needy citizens. The 1980 and 1981 funding levels for Community Health Centers were $320 and $325 million respectively, with the Carter Administration having proposed a $50 million increase for 1982. Funding for Migrant Health Centers was set at $40 million in 1980, with both the proposed 1981 and 1982 levels for that program remaining at $43.4 million. The NRPCA believes that these funding levels, as well as the funding priorities, already reflect the current emphasis on belt-tightening and streamlining of Federally-supported programs. We therefore think we would be very much in line with that emphasis on fiscal restraint to urge a modest increase in funding for these programs in order to help them offset inflation, increased energy costs, and the costs of serving an increasing number of medically needy citizens due to both the cited economic factors and others. However, NRPCA believes that through continued emphasis on achieving greater efficiency in the management and operations of the health center programs, in combination with the support they have gained from their communities and states, existing centers can continue to be successful at current funding levels. As such, NRPCA would urge the Subcommittee to set the fiscal 1982 appropriation levels for the Community Health Center program at $325 million and the level of the Migrant Health Center program at $43.4 million.

The Primary Care Research and Demonstration (PCR&D) Program is another program NPRCA would strongly urge warrants continued Federal support at its current level of $7 million.

The PCR&D program, the successor to the Health Underserved Rural Areas (HURA) Program, funds projects which seek to demonstrate the most cost-effective methods to provide primary health care to medically underserved populations. The emphasis of the PCR&D program has been to fund projects which make optimal use of existing resources, including administrative structures, while implementing innovative approaches to resolve issues related to the organization, delivery, and financing of primary health care in underserved areas.

NRPCA believes that the PCR&D Program, as the health center programs, is most consistent with current Federal priorities. Specifically the PCR&D projects have been demonstrating ways in which Federal involvement in and funding of health and other human services--even in areas of highest need--can be reduced in favor of increased state and local control and support. Toward those ends, the PCR&D Program is funding projects to demonstrate the value of varying ways of extending primary care services to underserved area by building on private sector resources, including those of medical schools, and referral hospitals; integrating various Federal, state, and local programs into unified delivery systems; developing service networks which link satellite clinics to one central clinic on administrative entity; and the use of such technology as telecommunications to achieve greater efficiency and effectiveness.

Although the list of project areas I just cited is not complete, it does underscore the Program's being in line with the Administration's proposals. Further, the PCR&D Program, in combination with the Community and Migrant Health Centers, have helped to put in place a structure which will enhance the ability of states and communities to continue to meet the essential human service needs of their neediest citizens. Indeed, to a significant extent, *positive trends currently noted in rural care, such as increased coordination among and integration of public and private resources, improved recruitment and retention of health personnel, and the overall increased accessibility of care, are in large measure the result of the combined and mutually enchancing success of The Community and Migrant Health Centers, the PCR&D program, and the National Health Service Corps. It is important that those successes are not used as indications that the programs which have achieved them are no longer needed. Our concern is that if significant cuts are made in funding for rural health programs, it will assure the dismantling of the existing rural health care delivery structures and result in rural areas having less access to care than before the programs were initiated.*

Finally, I would like to comment briefly on the National Health Service Corps (NHSC). As you are aware, issues attendant to physician supply and distribution are complex, and the NRPCA does not necessarily concur with some of the Administration's projections and assumptions on which they are based with respect to the future availability of physicians to rural areas. There remain too many variables and unknowns with regarding the level and direction of other Federally supported health service and reimbursement programs which may have significant effects on physicians distribution. Overall, however, based on straight projections of the number of students who will be in the placement program by 1980, the NRPCA would support a substantial reduction in new NHSC scholarships, and strongly endorses the proposal to allow students who currently have scholarships to complete their training, and to maintain the NHSC placement program. This support is given on the assumption, that the proposed reductions in funding for the Corps leave sufficient funds to provide for site preparation and other aspects of the placement program as well as to maintain the existing scholarships. NRPCA would also most strongly recommend that the effects of budget cuts, shifting priorities, and other factors affecting physician supply, specialty, and distribution be closely monitored and the need for the NHSC scholarship program or an alternative to it be reassessed at least by 1985.

Again, I greatly appreciate your consideration of NRCPA's testimony and would be happy to provide you with any additional information which might facilitate your review of the rural health programs on which I have commented today.

STATEMENT OF CATHY SCHOEN

The Service Employees International Union represents more than 650,000 workers nationwide and over 250,000 health care workers, including workers in over 20 community health centers. As consumers of health care and as health workers, we urge this committee to give strong support to the community and migrant health center program with an appropriation that allows the program to expand and to keep up with the cost of providing services. We beleive that this support is a necessary and essential component of the nation's commitment to assure all communities access to quality health care and, at the same time, to control health care costs. In the following statement we document the success of the centers program and the need for greater federal support.

Federal outlays for community health centers in fiscal year 1980 of $320 million represent a 62 percent increase over the past six years, far less than the 84 percent inflation rate during the same period. Despite the resulting 12% decrease in real program dollars, the program has achieved the remarkable feat of tripling the number of people served and more than tripling the number of projects funded through federal support. Table 1 documents the simultaneous increase in program services and decrease in real federal support.

This feat is the result of two major factors -- one positive, one negative. First the positive side. The program has dramatically improved its use of scarce federal funds through successful efforts to increase efficiency; to maximize use of delivery capacity; and to attract patients covered by insurance. Table 2 shows that in the last six years cost per visit has declined 31percent; the number of visits per provider has grown by 25 percent; administrative overhead has dropped 16 percent; and the percentage of operating costs covered by insurance has grown from 17 to 39 percent.

Notwithstanding this impressive record, restricted federal funds have had a negative affect. Growth has too often been at the expense of community health center workers and the ability of centers to provide a stable source of comprehensive care for their communities.

The failure of federal funds to grow with the costs of providing care and the expansion of the program has directly hurt the centers' ability to maintain adequate staffs and pay living wages. In Table 3 we contrast 1979/80 wages of some of our members in a California health center with average wages of comparable health care workers in neighboring health care facilities. The table shows wages lagging as much as 58 percent behind community wages. Column three shows that health center workers' annual incomes lagged poverty level budget estimates of the U.S. Bureau of Labor Statistics by up to 81 percent. In addition to poverty wages, this particular center has laid off some 53 workers for lack of funds and cut back on services. The cuts in staff and in wages are directly related to the decline in federal funds to the center.

Federal policy makers must remember that health care workers are the most important resource of a strong health center program. As a nation we can't expect health center workers to sacrifice their families' well-being to keep the program alive.

Federal funds are the cutting edge between adequate staff and salary levels on the one hand, and substandard service levels and even center closures on the other. Center commitment to serve all in need regardless of ability to pay leaves a 53 percent gap between costs of care, and revenues --from patients, insurance and state and local governments-- which must be covered by federal funds. Although many center administrators have already learned the expensive art of grantsmanship to counter scarcity and instability of federal funding, the funds have been stretched as far as possible. Current federal policies are already forcing workers back into hospitals and away from their own communities.

Viewed from the national health policy perspective as well as community health center workers' perspective, a weak federal commitment to centers just doesn't make sense. Not only have the centers brought down the costs of care provided at the center, they have also established a history of fighting inflation in the general health system by keeping people out of hospitals. Studies have shown that centers can reduce use of hospitals by as much as 25 percent in communities which otherwise would have relied on emergency rooms and hospital outpatient departments for care. This translates directly into lower costs of care. A recent Department of Health and Human Services study in 1979/80 of Medicaid users found that centers reduce total federal and state Medicaid dollars per person by 6 to over 50 percent by keeping people out of hospitals.

The center program is also the nation's primary mechanism to reach underserved communities. For our nation's urban wastelands and isolated rural communities, community health centers are one of the few programs of any kind that provide access to quality, preventive, and primary care services. Increased funding is essential to allow the program to do its job. A big backlog of applications for planning grants and start-up funds currently exists, yet federal resources are insufficient to support existing health centers let alone expand into new areas.

Accordingly, we urge your committee to increase the appropriation for centers in 1981 and in 1982 to allow at least for inflation. We also encourage additional funds to allow for expansion of the program.

The SEIU staff will be glad to provide additional information as necessary to document the need for expanding and continuing federal support of community health centers.

We thank the Committee and the Committee Chairman for this opportunity to submit our statement for the record.

TABLE 1: COMMUNITY HEALTH CENTERS' MAXIMIZE USE OF FEDERAL FUNDS
1974 - 1980

	1974	1980	%Change
Total Centers Users	1,600,000	4,300,000	+169%
Number of Centers	260	960	+269%
Federal Center Funds ($Millions)	$197	$320	+ 62%
1974 ($Millions)	$197	$174	- 12%

Source: Department of Health and Human Services Program, 1975-1980 Reports

TABLE 2: COMMUNITY HEALTH CENTERS SHOW DRAMATIC GAINS IN PRODUCTIVITY AND EFFICIENCY
1974 - 1980

	1974	1980	%Change
Cost per visit, Medical Care	$ 44	$ 30	- 31%
Number of Visits per Provider	3,072	4,100	+ 25%
Administrative Costs as % Total	25%	21%	- 16%
Insurance Coverage of Costs	17%	39%	+121%

Source: Department of Health and Human Services Prgoram Reports, 1975-1980

TABLE 3: COMPARISON OF WAGES IN A LARGE COMMUNITY HEALTH CENTER WITH COMMUNITY WAGES FOR HEALTH WORKERS AND BLS BARE NECESSITY BUDGET*--ANNUAL WAGES 1979/80

		Increase Needed to Bring Center to Community Level		
Occupation	Center	Public Hospital V. Center	Private Hospital V. Center	BLS Low Budget V. Center
Housekeeper	$7404	+22%	+33%	+81%
Med. Technician	7584	+51	+58	77
Clerk-Intermediate	7956	+28	+58	68
PDX Operator	8376	+19	+46	60
EKG Technician	8784	+11	+43	53
Licensed Vocational Nurse	9492	+16	+44	41

*BLS Budget for Bare Necessities in Los Angeles, California was $13,399 in 1979.

Source: SEIU Community Wage Survey of Los Angeles Health Facilities.

Statement of H. Carl Haywood

Impact of the Cuts

NICHD-Mental Retardation Research Centers

Cuts in the Mental Retardation Research Center (MRRC) program will eliminate for the forseeable future, promising areas of research on prevention and treatment of mental retardation. Since the research programs of each MRRC are specialized, cuts would lead to elimination of various specialized research efforts. Given that the Federal government would be reneging on its 20 year commitment to universities in midstream, and that universities are fiscally hard pressed, it is expected that these areas of research would be abandoned for the forseeable future. A minimum five year start-up period would be required to re-establish these areas of investigation, with leading university participation doubtful if the Federal government sets a precedent on abondoning previous commitments.

Loss of the Mental Retardation Research Centers would mean abandonment of the goal of halving the incidence of mental retardation by the year 2000 (along with the hope of a related reduction in current Federal government expenditures of 4.6 billion dollars per year for care of the mentally retarded). Thus, for every dollar "saved" in the Federal budget--more dollar expenditures would be required in serving disabilities which could have been prevented or greatly minimized.

MCH Funded University Affiliated Facilities

A recission of 4.457 million dollars for MCH training for FY 1981 would mean the immediate defunding of an estimated three to four of the 21 MCH funded University Affiliated Facilities (UAFs) starting July 1st of this year. Since these are constructed facilities with a 20 year print obligation between the universities and the Federal government, and with most university faculty being on a one year advance contract basis, this would impose a severe hardship on participating universities and could well result in legal actions. More significantly, for future children and their families, a defunding of three or four of the UAFs would eliminate a portion of the clinical population used by the MRRCs as a basis to test and demonstrate new methods of prevention and treatment. Consequently, the MRRC effort would be significantly downgraded by defunding UAFs. In addition, defunding of MCH supported UAFs could be estimated to have these additional consequences:

- Irreperable lifelong loss of service to an estimated 4,000 severely handicapped children: Approximately 30% of the children seen by UAFs are children with complex disorders that no state clinic has been able to diagnose and provide treatment. For these children, UAFs represent their last hope for accurate diagnosis and treatment. If diagnosed and treated, the impact of retardation is significantly reduced. Since early detection is vital, irreperable lifelong harm will be done by denying such services. States served by the defunded UAFs would bear the economic cost of serving children with higher disability levels, with an estimated increased service cost per state per year of many million dollars.

- Loss of regional prevention networks: The UAFs serve as a national network to implement within the states new methods of prevention and treatment. Loss of three or four UAFs would add years to the time period during which the rapidly developing research findings are actually implemented in states. This delay would mean that literally millions of children and their families would needlessly suffer mental retardation and other developmental disabilities and states would be stuck with care costs of about 1 million dollars over the lifetime of each severely handicapped child.

The proposed MCH training budget for FY 1982 would result in the defunding of approximately 7 of the 21 MCH supported UAFs. This cut would lead to similar but more extensive consequences than those listed above. Perhaps most significantly, regional groups of states would be denied a technical resource which would otherwise allow them to more effectively prevent and treat mental retardation and developmental disabilities. Since the MCH supported UAFs serve national and multi-state regional areas there is no practical way for states to replicate or fund these unique and irreplacable technical centers.

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BACKGROUND: Mental Retardation and Developmental Disabilities

An estimated 3% of the U.S. population suffers from mental retardation or other developmental disabilities. These conditions have a profound and often devastating effect on both the directly affected individuals and their families. The divorce rate is significantly higher for parents of children with developmental disabilities. There are over 200 known causes of mental retardation, and the known causes explain less than half the cases diagnosed. The cost to society of this disability is enormous. It has been estimated that the Federal government alone is spending 4.6 Billion Dollars on the treatment and care of individuals with mental retardation.

The impact of research on cases, prevention and treatment and the dissemination of research findings to States has paid great dividends and offers great promise. It has been estimated that for each case of severe retardation among males that is averted, the undiscounted total gain to society is almost $900,000 (1970 dollars). The President's Panel on Mental Retardation in 1962 observed that "the Panel has been mindful of the significant advances in the attack on mental retardation which have taken place as a result of research findings. Such errors in inborn metabolism as phenylketonuria, maple syrup urine disease, and galactosemia have been intensively studied and through the results of these studies, it has been possible to prevent many causes of mental retardation." In recognition of the practical potential for prevention and its importance in human and economic terms, President Nixon established as a national goal reducing the incidence of mental retardation by ½ by the year 2000. This goal, felt then and now to be a practical one which can be achieved through research, and the dissemination of knowledge to states will save society and Federal and State governments billions of dollars.

PROGRAM CONCEPT AND DESCRIPTION: Mental Retardation Research Centers

The President's 1962 Panel on Mental Retardation stated: "high priority should be given to developing research centers on mental retardation at strategically located universities and at institutions for the retarded." Congress created 12 National Mental Retardation Research Centers (MRRCs) constructed and established by P.L. 88-164. In order to receive construction funds, the host universities for these centers had to commit themselves to a minimum of a 20 year program of research on mental retardation, with the clear understanding that the Federal government would support that commitment throughout the 20-year period. The centers are now at mid-point; allowing for start-up, most of the Centers having been in operation for at least 10 years.

In many ways, these 12 MRRCs stand as a prime example of the carrying out of a Congressional mandate. Scientists in these centers have made substantial contributions to our basic fund of knowledge about the nature and causes of mental retardation and some mechanisms by which it can be modified, and the knowledge that they have produced has already been translated in many cases into applicable programs of prevention, treatment, education, community integration, and long-term rehabilitation of mentally retarded persons.

Generally, the scientific program of these centers is characterized as both biomedical and behavioral, reflecting characteristics of the problem of mental retardation. In fact, one of the great strengths of the MRRC program is that it is multdisciplinary in concept and in practice.

In three of the centers, important work is being done in the area called behavioral teratology, referring to the long-term effects of various chemical and biologic agents upon the development of behavioral and social processes. Scientists in one of these Centers have discovered long-term effects on behavior from certain chemicals, including common food additives, that are not necessarily reflected in identifiable physiological or structural changes in the laboratory animals being studied. Similarly, in another of the centers one of the scientists has discovered that alcohol ingested by females during pregnancy produces long-term behavioral effects on their offspring that are likewise not necessarily reflected in measurable structural changes in the animals. In fact, the fetal alcohol syndrome was actually discovered and first described in one of the Mental Retardation Research Centers as a result of that Center's work in animal and human behavioral teratology. Such work has two major effects: (A) it contributes to a better general understanding of the nature of teratogenic mechanisms, i.e., those mechanisms by which the development and ultimate functioning of children may be affected by drugs, alcohol, environmental chemicals, and even ingredients of supermarket food products, (B) such studies may contribute quite directly to the prevention of mental retardation by pointing out the specific dangers to developing children of the use of such drugs and other agents during pregnancy.

A researcher from one of the Centers has developed a method for transcutaneous monitoring of oxygen and carbon dioxide, known as the "Clarke electrode", that can be used in newborn nurseries. This device is placed directly on the skin, and does not require taking blood samples or other intrusive or invasive methods for determining levels of oxygen and carbon dioxide. Very low levels of oxygen can cause permanent brain damage and lead consequently to lifelong mental retardation, while the very high environmental oxygen levels that have been useful in preventing brain damage in premature infants have been associated with retrolental fibroplasia, often resulting in blindness. With this monitoring device, nurses and physicians in neonate nurseries can know immediately when there are changes in the blood levels of oxygen and carbon dioxide in infants, and can institute remedial procedures in time to prevent brain damage. Because relatively minor changes in glucose levels are often associated with metabolic disorders that lead to permanent mental retardation, the same researcher is currently perfecting a transcutaneous glucose electrode that will operate on similar principles and allow instantaneous detection of changes in blood levels of glucose. Early detection allows treatment measures that can forestall the mental retardation.

A scientist in another of the MRRCs has studied the economic effects of neonatal screening for metabolic disorders that are related to mental retardation. Taking phenylketonuria (PKU) as an example, she has found that the screening test costs 33 cents per baby. Treatment of PKU includes a carefully controlled diet and medical management and is almost always successful in preventing mental retardation. Such individuals have been known by now to grow up with no intellectual impairment, to hold jobs, graduate from school, and in general assume the broad responsibilities that society expects of its citizens. By contrast, an untreated infant with PKU will spend many years, perhaps 40 or 50, in a residential institution, usually at public expense. A current estimate of the cost of institutionalization of severely and profoundly retarded individuals is between $20,000 and $40,000 per year. If one calculates the cost of lifetime institutionalization, the likely earnings of a non-retarded person who might have been retarded without screening and treatment, the actual cost of screening and treatment, not even considering such dimensions as lost taxes, it becomes clear that screening and treatment for such disorders as PKU lead to a net economic saving of at least $1,000,000, and perhaps as much as $2,000,000 for each individual identified.

Clearly, it is to our economic benefit to continue these programs of research, and to support them adequately. Work is constantly going forward in these 12 Centers to identify the specific disorders that lead to mental retardation and to develop effective and cost-efficient methods of screening, followed by effective methods of treatment through which the mental retardation related to such disorders can be prevented. These detection and treatment procedures are then put in practice in our allied program, the University Affiliated Developmental Disabilities Training Facilities (UAFs), where they are incorporated quickly into the training of new clinicians.

We know, largely through work done in these 12 centers, that carefully devised and applied programs of early identification, early education, parent training, pediatric management, and follow-through in the school years can greatly reduce the number of persons in such circumstances who are ever diagnosed as mentally retarded. Prevention on all these levels is being pursued vigorously in these Centers, together with basic research on the fundamental processes and mechanisms that will make possible further advances in prevention of mental retardation.

Note the research jointly done by the MR Research Centers and the UAFs has supported the implementation of virtually all Federal/State programs for the mentally retarded. As only one example, recently completed cooperative research has substantiated the value of developmental services for children at high risk for mental retardation and thus provides a technical basis for the developmental component of the Head-start program. The coordinated interdisciplinary character of the two joint centers' programs provides a national resource which is unique in its ability to develop and test improved methods for preventing and treating mental retardation.

In spite of everything we can do to prevent mental retardation, a substantial number of individuals are born with retarding conditions, so it is important that we continue to develop, evaluate and disseminate methods for ameliorating the behavioral and social effects of mental retardation, for making the learning processes of retarded individuals more efficient, for increasing their integration into society, and for decreasing their dependence on institution and on other persons. That is the primary focus of behavioral, social, and educational research that takes place in these Centers. Psychologists and special educators in the Centers have made quite significant advances in methods for teaching retarded individuals, including even those who are severely retarded, the necessary skills to care for their daily requirements. Many of these training methods were direct results of basic research in behavioral psychology that started years ago in the animal laboratory as experiments on the learning mechanism of pigeons. Several of the MRRCs are especially active in this kind of behavioral research. Through such research emphases, as well as our close alliances with the UAFs, we are daily gaining in the ability to translate this fundamental behavioral technology into training methods that can be used successfully by a wide variety of persons, including parents and other family members. Widespread use of these training methods has already reduced substantially some of the costs of caring for retarded persons because they are able to do more for themselves and they require less constant attention.

Much is being done in the biomedical sciences. We are annually discovering new applications of fundamental techniques developed in this field 20 years ago, such as prenatal diagnosis through amniocentesis and karyotyping, with new capability of diagnosing a wide variety of potentially retarding disorders. Such advances must be followed up with appropriate treatment methods in order to forestall the consequent mental retardation. Research on characteristics of cell membrane functioning and malfunctioning promises to shed new light on a wide range of behavioral and structural developmental phenomena. Similarly, basic research on neuronal growth has reached a critical stage at which the promise of new understanding is great and the need for uninterrupted research is compelling. New research on brain enzymes, acting at the vital synaptic junction of neural cells, promises to provide extremely important keys to both the understanding of brain functions and the possibility of enhancing brain functions through biochemical intervention.

An example of research in the MRRCs that has shown significant promise but is still going forward and will require continued investment to complete follows: Research on the structure of the hypothalamus has revealed a group of cells that appear to act as "scavengers," protecting the brain from viral infections by attacking invaders such as viruses. As is true for other organs, there may be a critical period when these scavanger cells are not fully developed or functioning. Identification of this critical period, now under investigation, could help to prevent brain damage caused by a viral infection in the mother or infant, and thus prevent a major source of mental retardation.

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PROGRAM CONCEPT AND DESCRIPTION: University Affiliated Facilities (UAFs)

UAFs (and the UAF Satellite Centers) constitute a national and multi-state network working with National Institute for Child Health and Human Development supported Mental Retardation Research Centers to ensure that the latest possible knowledge is available throughout the service system. The national UAF network also works with local and state hospitals, well-baby clinics, treatment centers and other programs to provide leadership in states and local communities in applying knowledge, tests, and services to minimize and prevent mental retardation.

The 47 UAFs located in 34 states initiate and disseminate effective and efficient diagnostic and treatment methods through:

- serving individuals with complex conditions otherwise untreatable,
- providing technical assistance to state and local agencies treating the retarded,
- training working professionals and students in exemplary treatment methods, and
- assisting state and local planning agencies in maximizing available resources for effective diagnostic and treatment services.

Through their innovation and leadership, UAFs have built the capacity of local and state treatment systems and broken the barriers between states for effective and cost efficient regional treatment programs. Through their activities in actual treatment and diagnosis, UAFs represent a bridge to bring about new program development among relevant agencies within a state. Furthermore UAF programs have been notable by accepting high standards as part of a national network and organization (AAUAP) dedicated to developing and implementing new methods and technologies. An outgrowth of the leadership role and demonstrated expertise, UAFs are now regarded as the key source of tertiary care for mental retardation and developmental disabilities in their communities, states, and regions.

The following brief statement of national, regional, and local/state functions is in line with the stated requirements of legislation funding UAFs: 1) Maternal and Child Health's (Title V, SSA) emphasis on professional training and tertiary care for handicapped children and 2) the Developmental Disability Administration's and Act's emphasis on coordination and administrative support to implement a national network of UAFs and conduct national, regional, and local training activities.

The best diagnostic and treatment services for the developmentally disabled and mentally retarded are, at the same time, the best economic policy for the United States. When services are aimed at a rounded habilitation program with the goal of independent functioning, three results are achieved:

1. The mentally retarded individual leads a more fulfilled and dignified life.
2. Stresses on families of the mentally retarded are relieved.
3. Economic resources required for expensive institutionalization and maintenance (estimated to cost up to 1 million dollars over the life of a mentally retarded individual) are saved for more beneficial treatment and government savings.

When screening and diagnostic services achieve prevention of mental retardation, savings are realized through the absence of costly programs resulting from faulty or late diagnosis.

UAFs serve the nation, their regions, states, and localities through exemplary service ining working professionals and future leaders in the field, and research and dissemination of the latest knowledge on effective and efficient methods of treatment.

On a national level, UAFs have the lead role in bringing new knowledge to the field. This role is facilitated through the co-location of ten UAFs and Mental Retardation Research Centers (MRRC). UAFs are able to stimulate MRRC research based on real need and are further able to implement the results of successful research and spread those results to affiliated local and state agencies. In addition, UAFs are able to serve a national role in evaluating other applied research and implementing techniques at their facilities and affilated agencies. The thorough and rapid translation of useful research to diagnostic and treatment settings has the direct result of improving the quality of care for individuals and the operating efficiency of UAF treatment programs and those of surrounding agencies. Through a leadership position in research and training, UAFs train individuals for positions of leadership in national, regional, and state Developmental Disabilities programs.

The second national function performed by UAFs is the development and implementation f state of the art techniques and technologies that can be used by all service providers or the developmentally disabled. UAFs pioneered the use of telecommunications (audio conferencing, electronic mail, tele-lecturing) as a means of extending needed service and training programs to underserved populations. These efforts have placed UAFs in a leadership role for public and private sector organizations in taking advantage of new cost efficient communications systems. In addition, UAFs 7 years ago developed a comprehensive database system for documenting and analyzing training and service activities to monitor current programs and meet future needs (see I.C.P. Special Report for UAF database profiles). Other national state of the art programs include prevention technology (regional PKU screening programs), programs for the aging developmentally disabled, integration of the developmentally disabled into Head Start settings, manpower planning, coordination of services to the handicapped under Title XX, and new methods of promoting effective and efficient service delivery.

The combined national efforts of UAFs translate directly into benefits for regional, state and local agencies and service providers. The following two examples are indicative of the regional focus of UAFs: A) In the area of diagnosis and treatment, UAFs play a key regional role. Many UAFs see clients from surrounding states and provide technical assistance to agencies in surrounding states i.e., UAFs in Baltimore, Md.; Bronx, N.Y.; Cincinnati, OH.; and Kansas City, MO. to name a few. B) In the area of screening and diagnosis, UAFs provide genetic services accessed by surrounding states. The UAFs represent the only national network of genetic services specifically for the developmentally disabled.

UAFs extend their influence beyond their states of location through the active outreach to surrounding state agencies and programs for training and necessary support services. They offer the potential for rational, systematic resource use for complex issues and conditions. In addition to the national role as innovators and researchers, the regional role as providers of needed training and services, UAFs serve their particular states and local communities in a broad range of activities.

A) UAFs are often the key tertiary care providers for their local communities and technical assistance resource for their states. A sample of twenty-one UAFs indicated that together they provided full spectrum care for over 25,000 developmentally disabled individuals. In addition, the 47 UAFs combined maintain coordination, technical assistance, and consultative relationships with over 1,200 local and state agencies. B) In the area of training, UAFs provide a key resource for in-service and other special training for DD students, professionals, and paraprofessionals (nearly 100,000 trained FY 1979); extensive training for students in DD related fields (over 14,000 trained FY 1979); training for interdisciplinary activities as required under the DD Act and P.L. 94-142; and special training for State DD Councils. C) Finally, UAFs provide valuable leadership in the coordination of state and local treatment programs by bridging the gap between state, local, and voluntary agencies and service providers.

The material discussed in this section outlines the strengths of the UAF program in atment, training and research. To understand the true strength and need for UAFs, it only necessary to think of the DD community without UAFs. All treatment, training, and research activities indicated in the I.C.P. Special Report to Congress would be subtracted from the effort to provide effective and efficient services to the developmentally disabled; and no national, regional, state/local resource would be available to provide an effective model and guide for the billions of dollars spent each year by all government agencies on the developmentally disabled.

SUMMARY

The MRRCs are directly linked to the University Affiliated Facilities (UAFs) that were created under the same legislation that created the MRRCs. That alliance is extremely important both to the research programs of the Centers and to the quality of training and service to mentally retarded and other developmentally disabled persons. Indeed, it is this collaborative relationship between research and training, both of which e closely related to the delivery of excellent services, that has strengthened both the research programs and the training programs. The MRRC and UAF Directors wish to encourage this continuing relationship by urging increased and correlated support for the Maternal and Child Health Research and Training appropriations and support of the University Affiliated Facilities' portion of the Developmental Disabilities Assistance Program. If either component of this productive partnership is unable to survive because of lack of adequate funds, the other partner, either a MRRC or UAF, in the manner of a biological symbiosis, will find its own health seriously impaired.

The great humanitarian vision of the 88th Congress, expressed in the creation of the MRRCs and UAFs, has been partially achieved. Great progress has been made, and even greater progress is in sight. The Centers are facing a mid-life crisis in which our ability to bring about long-range and very substantial savings in human suffering and in public funds depends upon continued and sharply focused support that only you can provide. The choice is yours. In the words of a current television commercial, "You can pay now, or you can pay later"... and later, and later. And later costs more.

Attachment

MENTAL RETARDATION RESEARCH CENTERS
UNIVERSITY AFFILIATED FACILITIES

Mental Retardation Research Centers

Mental Retardation Research Center, The Neuropsychiatric Institute, Los Angeles, California
John F. Kennedy Child Development Center and the B. F. Stolinsky Research Laboratories (Center for Research on Mental Retardation and Human Development), Denver, Colorado
Joseph P. Kennedy, Jr., Mental Retardation Research Center, Chicago, Illinois
Kansas Center for Mental Retardation and Human Development, Lawrence, Kansas
Mental Retardation and Human Development Research Center, Boston, Massachusetts
Eunice Kennedy Shriver Center for Mental Retardation, Inc., Waltham, Massachusetts
Rose F. Kennedy Center for Research in Mental Retardation and Human Development, Bronx, New York
Child Development Research Institute, Chapel Hill, North Carolina
Institute for Developmental Research, Mental Retardation Research Center, Cincinnati, Ohio
John F. Kennedy Center for Research on Education and Human Development, Nashville, Tennessee
Child Development and Mental Retardation Center, Seattle, Washington
Harry A. Waisman Center on Mental Retardation and Human Development, Madison, Wisconsin

University Affiliated Facilities (including Satellite Centers)

Center for Developmental and Learning Disorders, Birmingham, Alabama
Dine Center for Human Development, Navajo Community College, Tsaile, Arizona
Division of Clinical Genetics and Developmental Disabilities, Irvine, California
University Affiliated Facility, The Neuropsychiatric Institute, Los Angeles, California
University Affiliated Program, Children's Hospital of L.A., Los Angeles, California
John F. Kennedy Child Development Center, Denver, Colorado
Georgetown University Child Development Program, Washington, D.C.
Mailman Center for Child Development, Miami, Florida
Georgia Retardation Center, Athens & Atlanta, Georgia
Hawaii University Affiliated Facility, Honolulu, Hawaii
Illinois Institute for Developmental Disabilities, Chicago, Illinois
Developmental Training Center, Bloomington, Indiana
Riley Child Development Center, Indianapolis, Indiana
University Hospital School, Iowa City, Iowa
Kansas University Affiliated Facility - Kansas City, Lawrence, Parsons; Kansas
Human Development Program, Lexington, Kentucky
Developmental Disability Center for Children, New Orleans, Louisiana
John F. Kennedy Institute, Baltimore, Maryland
Developmental Evaluation Clinic, Boston, Massachusetts
Eunice Kennedy Shriver Center, Waltham, Massachusetts
Institute for the Study of Mental Retardation and Related Disabilies, Ann Arbor, Michigan
Child Development Section, St. Paul-Ramsey Hospital, St. Paul, Minnesota
Mississippi University Affiliated Program , Jackson, Mississippi
University Affiliated Facility, Kansas City, Missouri
Montana University Affiliated Program Satellite, Missoula, Montana

Meyer Children's Rehabilitation Institute, Omaha, Nebraska

Institute for Human Services, Union, New Jersey

Rose F. Kennedy Center, Bronx, New York

Developmental Disabilities Center, The Roosevelt Hospital, New York, New York

University Affiliated Diagnostic Clinic for Developmental Disorders, Rochester, New York

Mental Retardation Institute, Valhalla, New York

Division for Disorders of Development and Learning, Chapel Hill, North Carolina

Ohio University Affiliated Center for Human Development, Athens, Ohio

University Affiliated Cincinnati Center for Developmental Disorders, Cincinnati, Ohio

Nisonger Center for Mental Retardation and Developmental Disabilities, Columbus, Ohio

Center on Human Development, Eugene, Oregon

Child Development and Rehabilitation Center, Portland, Oregon

Elizabethtown Hospital for Children and Youth, Elizabethtown, Pennsylvania

Developmental Disabilities Center, Philadelphia, Pennsylvania

Child Development Center, Providence, Rhode Island

University Affiliated Program of South Carolina, Rock Hill & Columbia, South Carolina

Center for the Developmentally Disabled, Vermillion, South Dakota

Child Development Center, Memphis, Tennessee

University Affiliated Center for Developmentally Disabled Children, Dallas, Texas

Exceptional Child Center, Logan, Utah

Center for Developmental Disabilities, Burlington, Vermont

Child Development and Mental Retardation Center, Seattle, Washington

University Affiliated Center for Developmental Disabilities, Morgantown, West Virginia

Waisman Center on Mental Retardation and Human Development, Madison, Wisconsin

ATTACHMENT

Selected UAF Program Descriptions

The Center for Developmental Disabilities, affiliated with the University of South Dakota in Vermillion, South Dakota, has as its prime mission the provision of interdisciplinary services and training and, information dissemination and technical assistance to the state of South Dakota.

CDD provides a state-wide outreach program for medical and therapeutic services. In addition, service programs are provided for school districts, and community treatment centers. 1,200 developmentally disabled children and adults were treated by CCDD in FY81.

In addition, CDD provides core training to 1,200 undergraduate and graduate students in mental retardation and its treatment, and special training to over 600 working professionals and paraprofessionals state-wide. Information dissemination and technical assistance is offered through a resource center run by CDD. The resource center circulates instructional materials free of charge to 1,700 individuals on a yearly basis. CDD provides a unique state-wide resource for the developmentally disabled and their parents otherwise unavailable to the citizens of the state.

The Mailman Center for Child Development, affiliated with the University of Miami, in Miami, Florida, has as its prime mission the production of professionals with the highest leadership potential in maternal and child health management in the area of mental retardation and other handicapping conditions, with specific emphasis on prevention, early detection, diagnosis, evaluation and intervention. The major objective is to train graduate students on exemplary interdisciplinary service models, integrating current knowledge calculated to improve the quality of services to the handicapped.

The program has provided for didactic instruction and clinical on-site practicum experiences concerning: (1) prevention and detection, (2) individual program planning and management , (3) developmental services, and (4) individual and family services. The patients are developmentally disabled persons up to the age of 17 years with a broad range of functional impairments. Trainees receive primary didactic and clinical training at the Mailman Center because of the variety of activities and experiences available, but training opportunities are available also through county health department units, the medical center teaching hospitals, as well as other community hospitals, state mental retardation institutions, group homes and parent resource centers.

Over the past five years, 196 students have participated in the training program on a full-time basis from the disciplines of education, medicine, nutrition, psychology, speech and hearing,and social work. Of these students, 76 percent have since received masters-level degrees and 15 percent, doctorates. Ninety-one percent are employed by institutions or programs planning and delivering interdisciplinary services to the developmentally disabled. The center provides services to an average of 2,000 new patients annually with an average of 15,000 clinic visits. In addition, 1,100 infants-at-risk are followed for developmental appraisal on an annual basis and 1,400 new patients are evaluated yearly by the craniofacial abnormality program.

The Child Development and Rehabilitation Center is part of the Crippled Children's Division (CCD) connected with the University of Oregon Health Science Center in Portland, Oregon. CCD is the agency established by Oregon law charged with the responsibility of extending and improving services to children under the age of 21 who are crippled, or who are suffering from diseases which may lead to crippling conditions. CCD conducts a state-wide program to locate crippled children; to provide diagnostic evaluation; to assist and counsel parents who are financially unable to provide the necessary care for their children, and to offer consultation and community outreach services to physicians, public health departments, agencies, schools and others who refer children for evaluation.

CCD is the only center where crippled children's services and a university affiliated program are combined. Both of these programs are funded by MCH under Title V. During calendar year 1980, this UAF served 5,079 patients. Model outpatient diagnostic and treatment programs for handicapped persons and their families serve as major vehicles for interdisciplinary training and exemplary service.

The follow-up of very high risk infants from the neonatal intensive care unit, U.O.H.S.C. Hospital, is an outstanding program service which is the result of a cooperative effort of Title V agencies, the U.O.H.S.C. perinatal devision, and the UAF.

Increasing emphasis is being placed on training of community professionals through workshops and outreach programs. For example, during calendar year 1980, 394 trainees from various disciplines, including 80 medical students, 32 nursing students, 8 dental students and 41 psychology students, on pre and post doctoral levels, received training in the care of the handicapped children. Their future involvement in the care of the handicapped will have been greatly enhanced by this program, without which they would have received little, if no, training in these conditions.

The Georgetown University Child Development Center, located in Washington, D.C., is an interdisciplinary training, service, and research program. Its mission is the improvement of the quality of life for the developmentally disabled. The Child Development Center provides a wide variety of service programs emphasizing self help and adaptive behaviors that make the developmentally disabled more independently functional. Training programs meet the core training and special knowledge needs of over 5,000 graduate and medical students, and professionals each year. The Center provides primary service to all developmentally disabled children and adults at the Georgetown Hospital. In addition, the Center reaches out to a variety of community schools, Headstart Programs, clinics, and treatment centers, providing needed training and tertiary care support. The Center also provides a two-year follow-up service for all "high risk" infants born at the University Hospital--a model service for all public and private hospital systems in the country.

The Center on Human Development, affiliated with the University of Oregon in Eugene, Oregon has been a national leader in the demonstration of several exemplary programs. This UAF has developed a national model pre-school program, integrating normal and handicapped children, enabling them to enter and advance in the public schools. This has clearly demonstrated that, with the proper training, developmentally disabled children can reach previously inconceivable academic goals. The Center on Human Develepment also operates a national model specialized training program to train severely handicapped adolescents and adults in work skills. The interdisciplinary training program at the Center on Human Development is also strong, providing training to, among others, paraprofessionals working in the classroom with developmentally disabled children, and students in the fields of adaptive physical education and vocational training. Students in the areas of special education, early childhood education, and education for the severely handicapped also receive interdisciplinary training through the UAF.

The Diagnostic and Treatment Unit (DTU) of the Harry A. Waisman Center on Mental Retardation and Human Development, affiliated with the University of Wisconsin - Madison served 1,199 clients between July, 1978 and June, 1979, and provided training to 6,520 individuals during the same period. As indicated by these figures, the DTU has extensive service and training programs. Training is provided both through coursework and seminars, and through observation, participation and case management at clinical sites. The DTU has established a cooperative effort with the State Developmental Disabilities Council to utilize the DTU Medical Genetics Program to increase public awareness about amniocentesis. The DTU also has a very strong Metabolic Clinic program, whose functions include a review of the status of adolescents and adults with PKU. The DTU has also established cooperative ventures with a number of other agencies and programs, including the Wisconsin Division of Community Services, Head Start, and Northern Pines Unified Service Center.

The Temple University Developmental Disabilities Center, in Philadelphia, Pennsylvania, established in 1972, offers a wide range of programs and services which, between July, 1978 and June, 1979, served a total of 1,802 clients, and trained 2,779 students, professionals, paraprofessionals, parents and others. The Temple University DD program works cooperatively with the Commonwealth of Pennsylvania to operate the Woodhaven Center, which provides short-term, intensive habilitative services for mentally retarded individuals to enable them to move on to community-based programs. Medical and health training, diagnostic and outpatient treatment are provided through the St. Christopher's Handicapped Children's Unit. The Temple UAF also has active programs in Evaluation and Research, and Advocacy Training. The UAF maintains an active Community and Regional Program Unit which provides assistance to state and community agencies, other colleges and universities, and groups such as the Pennsylvania Association for Retarded Citizens and the United Cerebral Palsy Association.

The Elizabethtown Hospital for Children and Youth in Elizabethtown, Pennsylvania, affiliated with the Penn State University M.S. Hershey Medical Center, is the newest member of the A.A.U.A.P. The service aspect of the program is oriented towards providing rehabilitation and habilitation programs to children, youth and young adults. Training is offered through such forums as seminars and practicum experience. Students receiving practicum experience are involved with inpatient teams and most outpatient clinics. The students are also trained through interdisciplinary clinical education classes, weekly team conferences, and participation in special projects and specialty clinics.

The Hawaii University Affiliated Facility Satellite Program (the Handicapped Services Training Program) in Honolulu, Hawaii, was originally funded in 1978. It's primary goal is service oriented; it works on a cooperative basis throughout the state and Pacific Basin to ensure the best use of resources and increase opportunities for quality services. In its short history, the Hawaii Satellite has built a wide range of achievements in the areas of service, training, technical assistance, planning, development of public awareness, and dissemination. The Hawaii Satellite has worked closely with programs and agencies such as the Waianae Infant Stimulation Program, Honolulu Community College, Bishop Museum, the Protection and Advocacy Office, the Hawaii Association for Retarded Citizens, Easter Seal, state Departments of Health, Education, Social Services, the state Division of Vocational Rehabilitation, and the Hawaii Developmental Disabilities Council.

The University Affiliated Facility for Developmental Disabilities, located at the University of Missouri - Kansas City, is relatively young, having been established at its present location in 1977. Nevertheless, the UAF has already established a cooperative relationship with the Governor's State Advisory Council for Mental Retardation/Developmental Disabilities which has brought about a project for training administrators of community-based developmental disabilities programs. The UAF has also worked with the Governor's Office of Budget and Program Planning to develop a research project to study the short-term effects of in-service training on clients and direct care providers of service in community-based agencies. The UAF also offers preservice training, and has worked with other university divisions, such as the schools of law and dentistry, to ensure the addition of coursework on developmental disabilities to the regular program.

Since 1975, West Virginia University has been the home of the University Affiliated Center for Developmental Disabilities (UAC). The UAC's focus is on a rural developmentally disabled population, and the UAC coordinates with local agencies to provide exemplary service in a number of outreach and classroom situations. The UAC was closely involved with the public schools in the development of the first classroom in West Virginia for severely and profoundly mentally retarded students. Through its outreach services, the UAC also provides technical assistance in areas such as prevention, early identification, service development, and coordination of available resources. Interdisciplinary training is provided both at the in-service and pre-service levels. From July, 1978 to June, 1979, 1,948 individuals received training through the UAC. The UAC also includes a research component, which currently focuses on early identification and intervention with high-risk infants.

The UAF Program of South Carolina consists of two centers: The Human Development Center, affiliated with Winthrop College in Rock Hill; and the Center for Developmental Disabilities, affiliated with the University of South Carolina in Columbia. Within the last four-five years, 2,913 clients and their families were provided such services as: Diagnosis and evaluation; case coordination; parent conferences and training; counseling; follow-up; behavior management; infant stimulation; occupational, physical and speech therapy; recreation, and tutoring. During this same time period, 3,753 pre-service students from 22 disciplines received interdisciplinary training. Also, 63 graduate students received financial assistance to attend school and receive supervised training while providing 20 hours a week each directing services to clients. 2,500 volunteers were trained to work with Special Olympics and other programs. The UAF training programs also provided training directly affecting Head Start and public school teachers, and Department of Mental Retardation employees. The UAF of South Carolina has extensive cooperative efforts throughout the state and region with such agencies and programs as the South Carolina Developmental Disabilities Council, the State Deinstitutionalization Task Force, and the Protection and Advocacy systems. The UAF has also provided training at regional MCH conferences and national training on the mentally retarded offender.

STATEMENT OF CLYDE E. SHOREY, JR.

My name is Clyde E. Shorey and I am Vice President for Public Affairs of the March of Dimes Birth Defects Foundation. I am pleased to testify before this Subcommittee on the continued funding of "Genetic Information and Counseling."

We are acutely aware of the tight budget constraints on all government programs and particularly the catagorical health programs. There are particular reasons for considering genetic services as a high priority item for special consideration. We therefore urge Congress to fund Genetic Information and Counseling at the FY 1982 Budget request of $20,368,000 with $17,068,000 allocated to Genetic Services (including sickle cell) and $3,300,000 for Hemophilia.

The March of Dimes, which is solely responsible for funding the research and development of the polio vaccine, believes that the full implementation of the genetic services program can lead to a similar breakthrough in preventing serious handicapping conditions resulting from genetic disorders. Genetic services is one of the most exciting, rapidly developing areas of health care. It must be made available to all the people of this country. At the present level of funding only 34 states have been able to start the funding of genetic services under their state plan with a grant from the federal program. All states, including New Mexico, Kentucky, Illinois and Alaska, which are not presently included, should be able to provide these essential services. All states still can't receive funding at the level of $17 million for genetic services, but approximately ten more states could receive grants.

Federal funding is essential because few states have laws mandating genetic service programs other than requirements for newborn screening for PKU and, in a smaller number of states, newborn screening for hypothyroidism, galactosemia and several other similar genetic conditions. Funding for genetic services is extremely limited since only a fraction of the costs are covered by states and third party payments, including Medicaid. Except for the addition of federal funding under the National Genetic Diseases Act, most of the delivery of genetic services is limited to approximately 100 major medical centers in which genetic service clinics were established with the individual institutions' own source of funding and often with the assistance of the March of Dimes.

The funds made available for genetic services under the National Genetic Diseases Act are used to support and expand statewide and regional genetic services delivery systems by building on state health departments, specialized service centers in universities and hospitals, together with voluntary and community service organizations and private physicians. Grants are made to state health departments and university or community centers in accordance with a state plan. The grants are coordinated and linked to other federal health care programs including Maternal and Child Health Programs, Crippled Children's Services Programs, Hemophilia Treatment Centers and Medicaid.

The primary objective of the program is to deliver genetic disease information and to provide education, testing and counseling services and medical referral for all persons seeking information who are suspected of having or transmitting a genetic disorder.

In the United States, one child in every 150 to 200 live births--or 15,000 - 20,000 infants per year--have a major genetic anomaly. It has been estimated that 12 million Americans carry true genetic diseases; 36 percent of all spontaneous abortions are caused by chromosomal defects; 80 percent of the incidence of mental retardation in this country is genetically related. Estimates have been made that at least one-quarter of all hospital beds and places in institutions for the handicapped are occupied by persons suffering from conditions that are wholly or partly genetic in nature.

Reduction of damage from genetic disease in most cases is dependent on identifying carriers of genetic disease traits through evaluation of family history and screening and diagnostic procedures. Carrier detection or such genetic disorders as thallasemia, sickle cell anemia and Tay-Sachs disease is possible.

Newborn screening of all live births can detect at least six different conditions causing mental retardation including PKU, hypothyroidism and galactosemia. If promptly detected at birth, severe mental retardation can be avoided and the baby will be able to lead a substantially normal life. All states are currently testing for PKU but substantially fewer are testing for the other conditions. The same blood sample can be used to detect all these conditions and in addition now can be used to detect sickle cell disease.

The Center for Disease Control has estimated that a nationwide hypothyroidism control program added to PKU screening should cost less than $5,900,000 and should produce a savings to society of $52 million a year. The state of California has estimated that adding hypothyroid and galactosemia screening of newborns to its present PKU screening program would increase its total costs of screening and treatment for victims of the three diseases from its present cost of $3.8 million to about $4.7 million. At the same time the long term costs averted by such a program for all three diseases would total an estimated $169 million--producing a cost benefit ratio of 36 to one. But the cost benefit ratios are not as important as the 35 PKU, galactosemia and hypothyroid cases in California each year that would lead healthy normal lives instead of being mentally retarded.

In addition to the identification of carriers of genetic disease traits and the testing of newborns so that those with a genetic disease may be identified for prompt treatment, genetic service centers also provide prenatal diagnosis to determine whether a fetus believed to be at-risk for a particular birth defect is or is not actually affected. Prenatal diagnosis is performed through the use of sonography, fetoscopy or amniocentesis. Through sonography high frequency sound waves produce a picture of an in utero fetus. By means of fetoscopy it is possible to obtain a direct view of the fetus and obtain fetal blood and skin cells. Amniocentesis is the process of withdrawing amniotic fluid. Through these techniques it is possible to identify all chromosome disorders, some malformations and approximately 90 biochemical disorders in utero.

Research in this area is proceeding at a phenomenal pace. As a result, when genetic diseases are diagnosed prenatally there are constatnly growing possibilities of treatment in utero.

Prenatal diagnosis of some defects is important because therapy to remove an excess of amniotic fluid and prevent premature labor may be desireable to allow the fetus to remain in utero for as long as possible. Additionally, the delivery can be planned so that the necessary neonatologists, anethesiologists, and/or pediatric surgeons are present.

Some defects may require induced premature delivery for early correction ex utero. In these situations continued gestation will allow continued deterioration of the fetus. Recent advances in the ability to pretreat the fetus with steroids to lessen the chances of respiratory distress syndrome make premature delivery a possible therapeutic tool.

Some malformations may influence the mode of delivery and require that a caesarean section be performed; such as where the abnormality would cause an obstruction in the birth canal or where the malformation required immediate surgical correction in a sterile environment.

Certain birth defects consist of fetal deficiency states which may be alleviated by _in_ _utero_ treatment. Fetal red blood cell deficiency secondary to blood destruction by Rh isoimmunization has been treated by transfusing red cells into the fetal peritoneal cavity--the intra-uterine transfusion. Recently, a fatal enzyme defect responsive to vitamin B_{12} therapy was treated by giving the mother massive doses of vitamin B_{12} which she transferred to the fetus. Medications and nutrients injected into the amniotic fluid are swallowed and absorbed by the fetus. Suggestions have been made to instill intra-amniotic thyroid to treat congenital hypothroidism or to instill intra-amniotic nutrients to treat intra-uterine growth retardation.

The last group of defects are those which interfere with fetal organ development and which, if alleviated, would allow normal fetal development to proceed. These malformations are candidates for _in_ _utero_ surgery, now still in the early stages of research.

Prenatal diagnosis may identify some major defects that result in a fatal outcome or severe crippling conditions or mental retardation such as some neural tube defects, anencephaly or Down syndrome. Knowledge of these conditions is necessary for parents to make informed decisions. However, it is important to note that out of many thousands of fetuses having prenatal diagnosis for a suspected birth defect, 96.5 percent were found not to have the defect in question. Those parents were then relived of any further worry about the outcome of the pregnancy. Studies have shown that this has permitted the resumption of nearly normal reproductive practices by at-risk families. Prior to prenatal diagnosis, knowledge by parents of a risk of producing a child with a major birth defect caused them to virtually stop reproduction or to seek termination of most pregnancies.

The provision of genetic services information, education, testing and counseling therefore produces the following benefits: a reduction in the number of severely handicapped and dependent individuals and of the tremendous costs to society; relieving of anxiety in parents during pregnancy who are bearing normal children, or the opportunity to prepare for the arrival of a child with defects; identification of treatable disorders so early intervention can be initiated; counseling prior to pregnancy so that informed decisions on pregnancy can be made; and early identification of major defects that result in a fatal coutcome, severe mental retardation or crippling conditions so that parents may make informed decisions.

If the benefits of this rapidly developing area of health services are to become available to all parents and newborns of this country, and if society is to have the benefit of the newborn who would otherwise be born with severe physical handicaps or mental retardation and also be spared the huge costs of longterm institutional care, the level of funding must be sufficient for all states to participate. It is currently operating with a minimum amount of administrative expense.

The March of Dimes, therefore, recommends the funding of Genetic Information and Counseling for FY 1982 at $20,368,000 with $17,068,000 for Genetic Services and $3,300,000 for Hemophilia.

Statement of Dr. Naomi Luban

Introduction

I am Dr. Naomi Luban. I have treated children and adults with hemophilia for several years and testified to the progress and needs of the Comprehensive Hemophilia Treatment Center program three times before this Sub-committee.

We want to tell you how deeply grateful we are for your past support of hemophilia research and care. There has been a revolution in hemophilia treatment and care in the last 10 years due to the availability of plasma clotting factors and to home infusion therapy. It is difficult to find other examples where science has been so swiftly translated into patient care.

I would like to tell you how your past and future support for comprehensive hemophilia treatment and hemophilia research has helped and will help thousands of hemophiliacs to be healthier, more productive citizens.

In 1974, The National Hemophilia Foundation representatives appeared before Congress in support of a bill providing for a national program of comprehensive hemophilia diagnostic and treatment centers. In response to the enormous health, social and economic impacts of hemophilia, Congress, in 1975, enacted Section 1131 of P.L. 94-63, which established the Comprehensive Hemophilia Diagnosis and Treatment Center Program and provided direct federal funding for the comprehensive care of hemophiliacs. In each of the first 4 years this sub-committee voted 3 million dollars in appropriations for this program. For fiscal year 1981 you increased this to 3.3 million dollars in the continuing resolution.

Your support has enabled twenty-three (23)* core comrehensive hemophilia centers. and 60 satellite service programs to be established. Approximately 6,000 hemophiliacs in the United States are served by this program. (This represents approximately 30% of the total hemophilia population.)

Comprehensive Hemophilia Diagnostic and Treatment Centers are mandated to provide:

- Multi-disciplinary diagnosis and treatment services,
- Professional and paraprofessional training,
- Accessible health care delivery through affiliation with other service providers,
- Psychosocial, financial and vocational counseling services,
- Individualized, written, comprehensive care plans for each treated patient, and
- Community participation through a community advisory board.

Federal funding is a small percentage of each of these centers' total revenues for mandated services; but their use has had a tremendous impact.

*The number of centers has not increased; one center was divided into two centers in fiscal year 1981.

Progress of Program

The impact of this program on the lives of hemophiliacs and their families is reflected in the program's progress towards its goals. Since my testimony last year, additional data supporting the impressive progress of the program has become available.

A survey of 16 federally-funded hemophilia treatment centers, done in 1980, underscores other studies' findings that the program has made tremendous progress: Between 1975, the year prior to program implementation, and 1980:

. The number of patients receiving regular comprehensive care increased more than three-fold.

. The number of patients seen at both primary treatment and satellite center sites doubled.

. The number of patients on home care increased three-fold.

. Significant reductions by at least one-half were observed in average days per year lost from work or school, average number of hospital admissions per year, average days per year spent as in-patients, average costs of health care per year, average out-of-pocket expenses per year.

. The percent of patients with third-party medical costs coverage increased from 74% to 91%.

. The percent of unemployed adults dropped from 36% to 13.6%.

A 1978 study performed by the National Institute of Advanced Studies, using a sample of 9 federally funded hemophilia treatment centers, showed that:

- The number of hemophilia patients served during the first year of federal funding increased 24% over the year prior to federal funding.
- The number of funded centers increased from 17 to 22 after the first year of funding.
- The total number of patient encounters increased at all centers studied, after federal funding.
- Federal funds have been used to increase the availability of dental, physical therapy, social and vocational services, making truly comprehensive care available to both the hemophilic child and adult.
- The number of patients on home care which enables earlier treatment and a more normal, independent lifestyle for the patient and his family increased after federal funding.
- Financial counseling services were established to maximize third party reimbursement, reduce out-of-pocket costs to patients, and decrease financial losses to the center and/or its host facility.

Federal funding has attracted both local government funds and encouraged third party reimbursement for hemophilia treatment. A survey of 43 State Crippled Childrens' Services (CCS) Directors showed that the presence of a federally-funded hemophilia treatment center in a state increases the number of hemophilia patients served by CCS by more than two-fold compared to states which do not have a federal hemophilia treatment center. Through the efforts of federal hemophilia treatment centers and The National Hemophilia Foundation, twenty-four (24) states now have State legislation mandating subsidization of blood products, and/or treatment programs for hemophilia. As a result of efforts by hemophilia center staff and patients, Blue Cross/Blue Shield and other health insurance companies have established insurance plans which cover hemophilia treatment.

Program Impact

What is the ultimate impact of this legislation on the lives of hemophiliacs and their families?

Hemophiliacs can now enjoy a nearly normal lifestyle due to breakthroughs in science and the existence of a top-notch treatment program which has translated those breakthroughs into diagnosis, treatment and care with remarkable speed. This has meant more opportunities for hemophilia patients in education, in employment, for a happy family life, as well as better physical and mental health. They can now infuse the missing clotting factor at home instead of interrupting their daily schedule to go to the hospital. They are more educated about their disease because of the intensive patient education provided by the comprehensive care team and can play a more active role in maintaining their health and preventing disability. Although they are from all socio-economic levels, their care is more affordable and those served through this federal program pay similar out-of-pocket costs.

Published studies and reports done by Peter Levine, M.D. in 1974, 1975, and 1979 show that the comprehensive health care and home therapy model promoted by this program has resulted in decreases in average annual cost per patient, in hemophiliac crippling, and in the number of days lost from school and work.

I am confident that these remarks have highlighted to cost-effectiveness of this federal program in your minds. Simply stated: Congress' investment in comprehensive care programs which promote home infusion therapy will pay off through a reduction in disability, unemployment, and medical care payments to hemophiliacs and families made vulnerable by the hardship of this chronic disease.

However, I believe our past testimony may not have emphasized clearly enough that Congress should protect its investment of 15.3 million dollars in the treatment of hemophilia by maintaining the level of care intended through the enabling legislation. Congress will get less for its money in the long run without higher appropriations to this program. Children and adults who have benefited from comprehensive hemophilia care continue to need this level of care in order to be as independent and productive as possible.

Let me briefly explain our needs and justify our appropriations request:

- There are several areas of the United States where little or no service for hemophiliacs exist. According to the Department of Health and Human Services and the results of a 6-month survey done by The National Hemophilia Foundation, 13 states and parts of 10 other states are not served by the federal comprehensive hemophilia treatment program.* It is estimated that 70% of the estimated total hemophilia population

*Sources: DHHS map of federal hemophilia centers (1/26/81); U.S. Directory of Hemophilia Treatment Centers.

does not have access to services through the federal comprehensive treatment center program. Although 24 states provide funds for hemophilia treatment programs, only a small percentage have treatment programs offering aspects of comprehensive care. The Department of HHS has approved nine (9) grant applications from medical facilities in these underserved areas in fiscal years 1978, 1979, and 1980, but funds were not available for these programs.

. While the original level of spending in the first year of the program was only 2.4 of the $3 million, the level of spending in past fiscal years have not allowed additional funds to be obligated for approved grants.

. Inflation has rapidly eroded the level of funding for this program by over $1 million over the period 1976-1981.** Centers are hard-pressed to continue to increase their level of services because funding has decreased by more than one-third.

. An increasing number of hemophiliacs is another consideration in the request for funds. According to a study report from the National Institute for Advanced Studies, the U. S. hemophilia population will increase as a proportion of the U. S. population by one-third over the next 30 years due to the increased survival rates from the availability of plasma concentrates. This means approximately 25,000 hemophiliacs by the year 2000, compared to the estimated current total population of 19,000. Thus, Mr. Chairman, the problem of hemophilia care programs is getting larger and not smaller.

. Finally, one across-the-board need at all existing treatment centers is the need to collect more data on the effectiveness of the program and to be able to cooperate in clinical research. Presently, the lack of funding to permit treatment center staffs to engage in these activities reduces the future development of administrative and clinical services.

Funding Request

I believe that on the basis of information attesting to the progress and needs of this program, the hemophilia community is justified in urging your support for an increased level of funding. We must protect Congress' past investment in preventive care, and the resulting reduction of long-term costs resulting from disability, by maintaining the level of treatment services and making them available to more hemophilia patients and their families.

We request an additional 1½ million dollars to make up for deficiencies present programs have developed and to expand what has been a successful model of care to under-served areas of the country. This will ensure that a full range of disciplines in comprehensive treatment teams, patient/family home care training, outreach services to urban and rural families, adequate third-party insurance, and better data collection are reinstated and/or maintained at the 23 currently-funded programs.

Approximately five new programs serving approximately 30% of unserved patients and their families can be established with a portion of these new dollars.*

Thus, we request an increased appropriation of $4.5 million. This is well within the authorizing limits of the current law.

Finally, we want to express our concern about the possibility of this program coming under the block grant system. Because the program serves a low density, scattered population, it cannot be administered without seriously compromising the present efficiencies of scale and the regional service networks built by this program.

Since the cure for hemophilia resides in new investigations, we are vitally concerned with survival and appropriate funding to the National Institutes of Health. In regard to the funding for the two institutes of the National Institutes of Health which support research of blood and blood diseases, we support the Coalition For Health Funding's recommendations as follows:

. For the National Heart, Lung and Blood Institute for fiscal year 1982, we request that you appropriate $625,000,000.

. In regard to the National Institute of Arthritis, Metabolism, and Digestive Diseases, we request that you appropriate $409,300,000.

. These appropriation levels include funds for training.

** Reference: Bureau of Labor Statistics, U.S. Department of Labor.

*Note: 5 programs at $150,000 each = $750,000 of the $1.5 million request.

EXHIBIT I

EFFECTIVENESS OF HSA FUNDED CENTERS

(THE COMPREHENSIVE HEMOPHILIA DIAGNOSTIC AND TREATMENT CENTER PROGRAM)

TABLE I

Evaluation of Patient Accrual

	Year prior to Implementation of P.L. 94-63	Fiscal Year 1980
Number seen at primary center	2,076	4,426
Number seen at affiliated centers	495	1,034
Total:	2,571	5,460
Number receiving regular comprehensive care	1,477	4,768
Number on home therapy	622	2,009

TABLE II

Evaluation of Patient Services: "Encounters"

	Year prior to Implementation of P.L. 94-63	Fiscal Year 1980
Hemophilia Clinic (Hematologist/Pediatrician/Nurse)	9,063	17,887
Orthopedist	1,357	4,347
Physical Therapist	1,741	7,436
Social Worker	2,395	16,966
Vocational Counselor	23	1,239
Psychiatrist/Psychologist	96	1,933
Genetic Counselor	147	1,433
Oral Surgeon	783	2,506
Mean Encounters/patient/year	6	13.9

Source: Federal Hemophilia Center Annual Report Survey, Results compiled by the New England Area Hemophilia Treatment Center, Worcester, Massachusetts in March, 1981. Based on reports from 16 federally-funded hemophilia treatment centers.

EXHIBIT I (Cont'd)

EFFECTIVENESS OF HSA FUNDED CENTERS

(THE COMPREHENSIVE HEMOPHILIA DIAGNOSTIC AND TREATMENT CENTER PROGRAM)

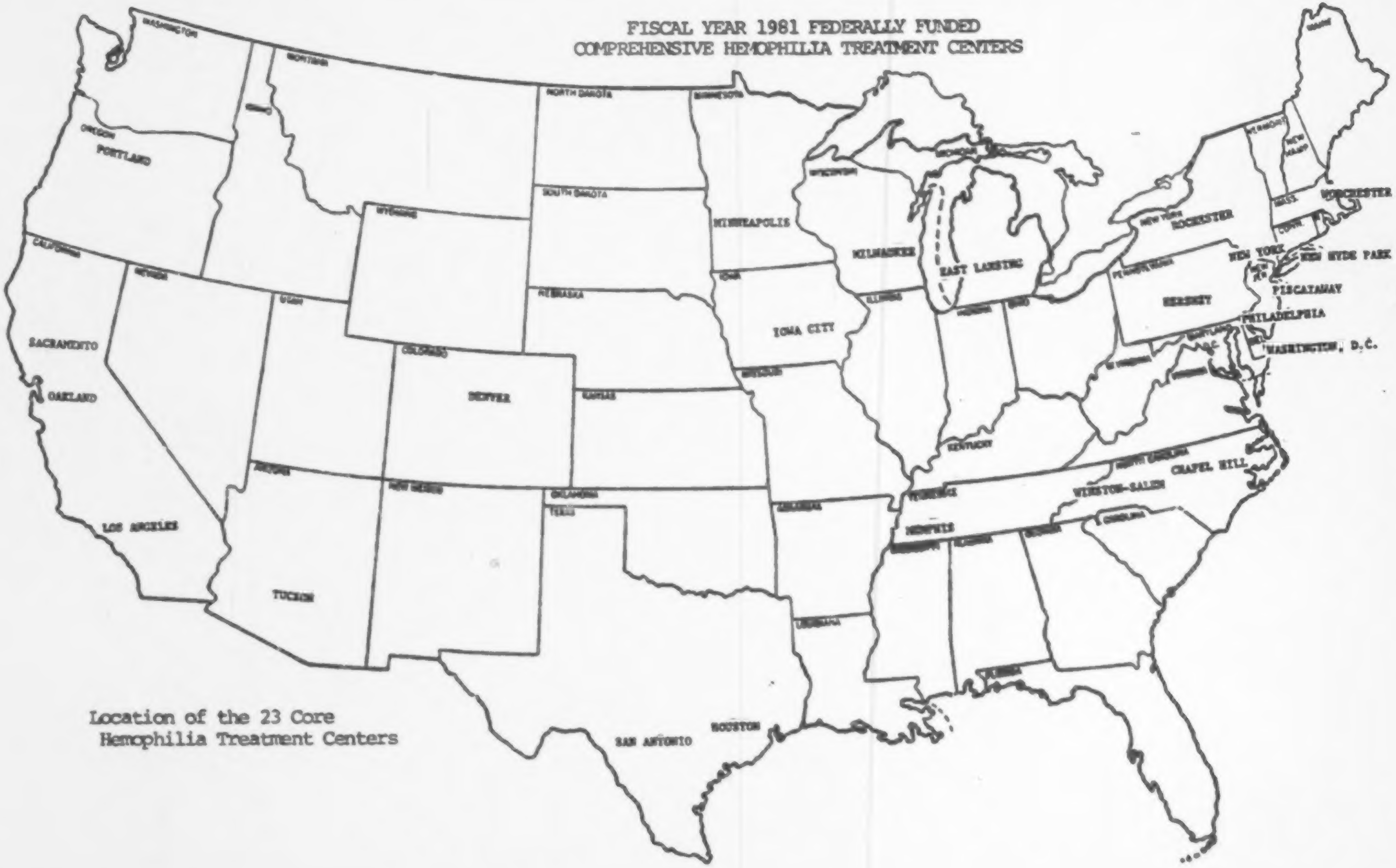
TABLE III

	Historical Controls (Year prior to implementation of P.L. 94-63)	Fiscal Year 1980
Average day/year lost from work or school	20-60	8.3
Average number of hospital admissions/year	6-36	0.71
Average days/year spent as in-patients	14-60	2.4
Average costs of health care/year	$8-22,000	$5,252
Average out-of-pocket expenses/year	$1-5,000	$ 388

		Fiscal Year 1979	Fiscal Year 1980
Percent of patients with third party coverage	74%	85%	91%
Percent of unemployed adults	36%	16%*	13.6%*

*Comparison figures, NHLBI Blood Resources Studies, 1972: 41% of adult hemophiliacs unemployed and on welfare.

Source: Federal Hemophilia Center Annual Report Survey, Results compiled by The New England Area Hemophila Treatment Center, Worcester, Massachusetts in March, 1981. Based on reports from 16 federally-funded hemophilia treatment centers.



FISCAL YEAR 1981 FEDERALLY FUNDED
COMPREHENSIVE HEMOPHILIA TREATMENT CENTERS

WASHINGTON
OREGON
PORTLAND
CALIFORNIA
SACRAMENTO
OAKLAND
LOS ANGELES
NEVADA
IDAHO
MONTANA
WYOMING
UTAH
ARIZONA
TUCSON
COLORADO
DENVER
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
SAN ANTONIO
HOUSTON
MINNESOTA
MINNEAPOLIS
IOWA
IOWA CITY
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
MILWAUKEE
ILLINOIS
MICHIGAN
EAST LANSING
INDIANA
OHIO
KENTUCKY
TENNESSEE
MEMPHIS
MISSISSIPPI
ALABAMA
GEORGIA
FLORIDA
NORTH CAROLINA
WINSTON-SALEM
CHAPEL HILL
VIRGINIA
PENNSYLVANIA
HERSHEY
NEW YORK
ROCHESTER
VERMONT
MAINE
MASS.
WORCESTER
CONN.
NEW YORK
NEW HYDE PARK
PISCATAWAY
PHILADELPHIA
MARYLAND
WASHINGTON, D.C.

Location of the 23 Core
Hemophilia Treatment Centers

HEMOPHILIA COMPREHENSIVE DIAGNOSTIC AND TREATMENT CENTERS

CORE TREATMENT CENTERS	SATELLITE SERVICE PROGRAMS
ARIZONA University of Arizona Tucson, Arizona	St. Joseph's Hospital & Medical Center Phoenix, Arizona
CALIFORNIA Orthopaedic Hospital Los Angeles, Calif.	Children's Hospital & Health Center San Diego, Calif. Children's Hospital of Los Angeles Los Angeles, Calif.
Children's Hospital Medical Center Oakland, Calif.	University of California San Francisco, Calif.
UCD Medical Center Sacramento, Calif.	
COLORADO University of Colorado Medical Center Denver, Colo.	University of Utah Medical Center Salt Lake City, Utah St. Vincent's Hospital Billings, Montana
IOWA University of Iowa Hospitals and Clinics Iowa City, Iowa	
MASSACHUSETTS The Memorial Hospital Worchester, Mass.	The Main Medical Center Portland, Maine Dartmouth-Hitchcock Medical Center Hanover, New Hampshire University Hospital of Vermont Medical School Burlington, Vermont Rhode Island Hospital Providence, Rhode Island University of Connecticut Health Science Ctr. Farmington, Conn.
MICHIGAN Michigan State University East Lansing, Mich.	University of Michigan Hospital Ann Arbor, Mich. Children's Hospital of Michigan Detroit, Mich. Bronson Hospital Kalamazoo, Mich. Beaumont Hospital Royal Oak, Mich. Ball Memorial Hospital Muncie, Indiana James Witcomb Riley Hospital for Children Indianapolis, Indiana
MINNESOTA University of Minnesota Medical School Minneapolis, Minn.	Mayo Foundation Rochester, Minn. University of South Dakota Sioux Falls, South Dakota
NEW JERSEY Rutgers Medical School Piscataway, New Jersey	Raritan Valley Hospital Green Brook, N.J. St. Michael's Medical Center Newark, N.J. Paul Kimball Hospital Lakewood, N.J. Middlesex General Hospital New Brunswick, N.J. Morristown General Hospital Morristown, N.J.

NEW JERSEY-con't	Elizabeth General Hospital Elizabeth, N.J.
NEW YORK Mount Sinai School of Medicine New York, N.Y.	Cornell University Medical Center New York, N.Y.
Long Island Jewish-Hillside Medical Center New Hyde Park, N.Y.	
Hemophilia Center Rochester, New York	The Ideal/Wilson Medical Center Johnson City, N.Y.
	Nicholos Noyes Memorial Hospital Dansville, N.Y.
NORTH CAROLINA School of Medicine, University of North Carolina Chapel Hill, N.C.	
Bowman Gray School of Medicine Winston-Salem, N.C.	
OREGON University of Oregon Health Sciences Center Portland, Oregon	University of Oregon Eugene, Oregon
	Medford Branch, Crippled Children's Division Medford, Oregon
PENNSYLVANIA The Milton S. Hershey Medical Center Hershey, Penna.	Allentown Hospital Allentown, Penna.
	Reading Hospital West Reading, Penna.
	St. Joseph's Hospital Lancaster, Penna.
Cardeza Foundation Hemophilia Center Philadelphia, Penna.	Children's Hospital of Philadelphia Philadelphia, Penna.
	Albert Einstein-Moss Medical Center Philadelphia, Penna.
	Wilmington Medical Center of Delaware Wilmington, Delaware
TENNESSEE University of Tennessee Memphis, Tennessee	
TEXAS University of Texas Medical School Houston, Texas	The Institute of Hemotherapy Houston, Texas
	The Hermann Hospital Houston, Texas
	The University of Texas Dental Branch Houstan, Texas
The University of Texas Health Science Center San Antonio, Texas	Texas Technical Health Science Center Lubbock, Texas
	Dr. Frank McDonald McAllen, Texas
WISCONSIN Milwaukee Children's Hospital Milwaukee, Wisc.	Gundersen Clinic LaCrosse, Wisconsin
	University Hospital, Univ. of Wisconsin Madison, Wisconsin
	St. Vincent's Hospital Green Bay, Wisconsin
	Marshfield Clinic Marshfield, Wisconsin
	Sacred Heart Hsopital Eau Claire, Wisconsin
DISTRICT OF COLUMBIA Childrens' Hospital National Medical Center Washington, D.C.	George Washington University Medical Center Washington, D.C.
	Fairfax Hospital Falls Church, Virginia
	Suburban Hospital Bethesda, Md.

STATEMENT OF MIKE GORMAN

Mr. Chairman, I will just make a passing reference to the Administration's block grant proposal because of limitations of time. I guess I am a long-standing survivor of block grant proposals, but the proposed prevention block grant which throws high blood pressure in with rat control, lead based paint programs and fluoridation takes the cake. We are quite ready to consider a thoughtful block grant proposal if it is based upon a thorough set of hearings pivoted upon a discussion of the rationale, if any, for a combination of programs which have some relevance to one another.

By way of contrast, and judging from briefings we have received from several officials of the Office of Management and Budget, program relevance and effectiveness do not seem to be paramount considerations. With very little knowledge of what a particular health program has done, you just throw it in with a bunch of unrelated programs and cut them by 25 percent. What is the rationale for a 25 percent cut?

Despite the fact that the high blood pressure project grant has been described in Congressional Appropriations Reports as the most cost-effective program in the past several decades, we have been constantly struggling to maintain our identity. It took us six years to get out of 314(d), a block grant which went to the states in a basket for any purposes they chose to support in the field of public health. Established in 1966, this magnificent block grant had such a sterling 15 year track record that it dropped from $90 million a year in its first years to a zero recommendation in the Fiscal 1982 Carter Administration budget. I am not the only one who shares these views. On March 2, the authoritative publication Medicine and Health described the "new" prevention block grant in these caustic terms: "A prevention block grant will include hypertension efforts, the remnants of the 314-d block grant to states, which once held all the hopes and promises that the Reagan Administration program now holds out..." Need I say more?

From the very beginning of the program, we were uneasy with the vague formula grant philosophy of the 314(d) people. In our program, we emphasize specific medical and public targets, accountability reports from each state, and constant cost-effective studies. In 1978, mainly through the efforts of Senator Schweiker, who is now HHS Secretary, we were finally able to get out from under 314(d) and achieve a visible identity of our own. Our grant became a competitive one in which states had to submit plans with particular emphasis upon bringing high blood pressure screening and referral for treatment procedures to the poor, the underserved and minorities. The Carter Administration didn't seem to be too happy with our newly earned visibility; last year it tried valiantly to move us out of the Health Services Administration and into the Center for Disease Control. They succeeded in moving the 314(d) program to the CDC, but we fought for our independence and we won, thanks to the support of friends in the Congress on both sides of the aisle. We had no business being in CDC. Their heaviest concentration is on the infectious diseases, but that is not our bag -- we are the first program to mount a national educational and prevention attack against a major chronic disease.

Mr. Chairman, if given the choice of much more money for high blood pressure in an amorphous block grant, or less money but a continuing identifiable targeted program, our Board would have no hesitation in choosing less money but continued identity, public visibility and strict accountability.

Testifying several years ago before this very Subcommittee, the distinguished surgeon Dr. Michael E. DeBakey, who is Chairman of Citizens for the Treatment of High Blood Pressure, was asked by one of the Senators about the various and continuing proposals for health block grants without any categories of disease singled out. Dr. DeBakey replied that he had been practicing medicine for 40 years, but had yet to encounter a patient who was threatened or died from a non-categorical disease.

But now to a specific discussion of the cost effectiveness of the high blood pressure program:

Blue Cross/Blue Shield, after a two-year study in a number of states, concluded in a report in 1980 that high blood pressure is "the most common adult chronic disease." According to figures from both the Health Services Administration and the National Heart Institute, 60 million Americans have high blood pressure. It is the consequences of high blood pressure which have the most devastating impact. Hypertension is the major factor contributing to the 500,000 strokes and the 175,000 stroke deaths which occur in this nation every year. It is also a major, if not the most significant, causal agent in the 1,250,000 heart attacks and the 650,000 heart attack deaths that occur each year.

The economic costs are staggering. A widely quoted study by the Public Services Laboratory at Georgetown University estimated the annual cost of strokes and heart disease at $50.4 billion. The direct costs of high blood pressure alone exceed $8 billion. If this Administration is really dedicated to cutting out waste and reducing costs, surely it must support every preventive measure designed to check the frightful medical cost inflation resulting from these two diseases alone. There has been a mounting tide of criticism from people all over the country concerning the soaring costs of health insurance premiums. The single largest contributor to these costs is cardiovascular disease, which runs about 30 percent of all premium payments, according to a recent study of the Ford Motor Company and other industries.

Some of us in the health field had been concerned about high blood pressure for a number of years; this concern led to the development of the high blood pressure project grants to the states for which I am testifying today. Our major difficulty is the fact that high blood pressure has no symptoms; it is known as the "silent killer." In a national survey conducted by the National Center for Health Statistics in the early 1970's, it was disclosed that more than one-half of Americans with high blood pressure did not know they had the disease. Only one-eighth of all hypertensives were on effective treatment despite the fact that a number of antihypertensive drugs had been introduced starting in the early 1950's. Put very simply, physicians were not taking advantage of this new knowledge coming out of research laboratories because they had learned in medical school that there was really not much in the way of treatment for hypertension.

In our travels about the country, a number of us tried to get the states interested in setting up an educational program leading to the detection and treatment of high blood pressure. Only a few states responded. We soon came to the realization that this was a national problem crossing state lines indiscriminately. It also impacted large segments of Americans in an uneven way. For example, blacks had twice as much high blood pressure as whites, and Hispanics were not far behind. This was obviously a national problem and needed national leadership. In 1972, we called upon Elliot Richardson, then Secretary of Health, Education and Welfare. We didn't have to do much convincing, because Secretary Richardson told us that his father, a distinguished surgeon at Massachusetts General Hospital, had suffered from high blood pressure which led to a stroke causing an end to a promising medical career. The Secretary laid down one central stricture -- the federal government would provide a small amount of seed money, but he wanted the private sector to carry on the major part of the job. As a result, we formed Citizens for the Treatment of High Blood Pressure with Dr. DeBakey as our Chairman and a distinguished group of medical and lay figures as sponsors of the Committee.

We took considerable time devising a limited grant to the states which would essentially provide money to hire and train the technical expertise they lacked. The federal government and the private sector would supply suggested guidelines for the treatment of high blood pressure based upon the latest medical evidence. The goal from the beginning was clear-cut: to take the basic and clinical research findings from the National Heart Institute and pharmaceutical laboratories and bring them to the people in need. To provide this material and to develop a total educational program, a national Coordinating Committee was set up including the American Heart Association, the American Medical Association, the American Nurses Association, the American National Red Cross and a host of additional national organizations, including Citizens for the Treatment of High Blood Pressure.

Legislation was introduced in 1975, setting up a broad formula grant to the states for detection and treatment of hypertension. Frankly, there wasn't much Congressional interest in this modest proposal. We were finally forced to attach our little program to a major renewal of several public health service authorities, and we were placed in 314(d), the basket grant to the states. Only $3,500,000 was appropriated to us for the first year, which meant that the grant to many less populous states approximated $50,000. We really got nowhere until the 1978 consideration of a Health Promotion and Disease

Prevention bill. Senator Schweiker was the key legislator in finally getting us out from under 314(d) and establishing us as a clearly visible competitive project grant. For the first time, states now had to submit detailed plans to compete for the existing money, with a Congressional directive that they concentrate a major portion of their efforts toward the underserved and minorities. Our modest financial success -- going from $3,750,000 in Fiscal 1975 to $20 million in Fiscal 1980 and the same sum in Fiscal 1981 is largely attributable to our new visibility.

We believe that the combined efforts of the Health Services Administration and the National Heart Institute have created the first believable prevention program against a chronic disease. As Dr. Robert Levy, Director of the National Heart Institute, put it recently: "in high blood pressure, our nation's primary goal is PREVENTION. It is the only truly cost-effective program...In five short years, the program has become what it is today, perhaps the most exciting example of successful disease prevention."

On receiving the coveted Albert Lasker Award for Public Service in 1978 for his pioneering work in establishing the National Hypertension Program, Secretary Elliot Richardson noted: "I know of no finer example of a close cooperative effort between federal, state and local governments and professional and lay people organized in their own communities."

Let us look at some hard facts. The drop in stroke deaths is the most dramatic. Up until several decades ago, stroke was regarded as a hopelessly incurable malady. In some cases, you could ameliorate the devastating side effects of a stroke, but cure was very rare. As many neurologists pointed out, the only way to handle a stroke was to prevent one. We have done this in our high blood pressure program. Since its advent in 1972, we have witnessed a miraculous 38 percent decrease in stroke deaths in this country.

There are numerous reports along the same line from industry. For example, Massachusetts Mutual Life Insurance Company reported on its three-year experience with an intensive high blood pressure detection and treatment program. All 2,700 employees were screened on regular schedules. Detected hypertensives were referred at company expense to their own physician. Reporting on the reduction of strokes in this program at the 1980 National Hypertension Conference, officials of Massachusetts Mutual reported the following:

"We believe our program to be the most feasible cost containing program currently available. Total cost of the program is $90 annually per hypertensive or $9 per capita of our total employee population. With the generally agreed price of a stroke at $15,000, we feel comfortable with the assumption that our program is indeed capable of reducing the cost of health care."

What is the status of our present high blood pressure effort? We have accomplished a great deal, but several recent clinical studies indicate that our major tasks lie ahead.

A little more than a year ago, we received a report on a massive six-year clinical study on the advisability of treating patients with mild hypertension. Until that study was completed, there wasn't any clear scientific proof of the benefits of treating this group of patients. The study demonstrated that the systematic, effective treatment of mild hypertension could reduce premature deaths among hypertensives by 20 percent. There are approximately 25 million Americans with so-called "mild" hypertension; these mild hypertensives comprise 70 percent of all hypertensives in the country, and this group alone is responsible for 60 percent of all hypertension mortality. The Hypertension Detection and Follow-up Study documented the fact that most of these mild hypertensives were not being treated. As the report noted: "Looking at it another way, tens of thousands of Americans with high blood pressure are now probably dying at an earlier age than they should...to the millions of Americans who have high blood pressure, this study says: get on treatment and stay on treatment. It will mean a much longer life...more years to spend with your loved ones. To the physicians with high blood pressure patients: take the necessary pains to make sure your patients follow your instructions and stay on treatment. It also says that if you have patients with mild hypertension, do not assume they do not require some form of treatment. If you do, you may be denying them years of life."

This study also proved that you could obtain very high compliance rates if you provided the community clinics and the skilled health personnel necessary for frequent monitoring of high blood pressure victims. This was particularly true in the case of minorities. Blacks, Hispanics, Orientals, etc. had very high rates of high blood pressure. However, where you introduce intensive community outreach clinic programs, you had very significant drops in high blood pressure among minorities. For example, in the intensive care segment of the HDFP study, the reduction of mortality among blacks was almost twice that among whites.

Building on these studies, the Surgeon General in the 1980 Prevention Profile Report submitted to the President and the Congress, as mandated by the 1978 law, proposed this realizable goal:

"By 1980, at least 60 percent of the estimated population having definite high blood pressure (160/95) should have attained successful long-term blood pressure control, i.e., a blood pressure at or below 140/90 for two or more years."

This goal requires that 36 million of the 60 million Americans who have high blood pressure be brought under successful long-term treatment in the decade of the eighties. This is a very large order, but in a report to a special committee set up by the Senate Appropriations Committee in 1980 to study the entire problem of high blood pressure, the Health Services Administration agreed to accept this as a long-term goal. Each year various programs within the Health Services Administration -- community health centers, migrant health programs, family planning and maternal and child health services -- see and treat millions of Americans. With the contemplated cuts in the hypertension grant and in most other HSA programs, how in the world will they be able to achieve this objective which the Congress has endorsed?

Working with the Health Services Administration and the National Heart Institute, Citizens for the Treatment of High Blood Pressure and other major medical organizations have made a special effort to reach the millions of Americans who comprise our minority population. In 1978, for example, we achieved an historic first by holding a national meeting in Los Angeles entirely devoted to how to reach Hispanics who are out of the mainstream of American medicine. At the National Hypertension Conference in Houston in 1980, we highlighted the truly magnificent hypertension outreach program to Mexican-Americans devised and administered by Dr. DeBakey and Baylor Medical College. We have task forces for every minority, and a national conference has been held by each since 1978.

These are compelling reasons for retaining the hypertension project grant as a national program. We need national leadership and visibility to conduct a broad educational and detection program. The active work among the minorities serves as an example. States vary enormously in their concentration of minority populations. In our programs for the blacks, we have given a first priority to the heavy concentration of blacks in large cities in a few states; working with Hispanics, we find an urban-rural combination, but largely concentrated in a few states again.

Worksite hypertension programs have begun to blossom in the last few years. We are concentrating on the worksite, because you have a central point to which your patients come each day. In the larger industries, you usually have a medical director's office which can take over the problem of screening and treating of employees. Your industrial nurse plays a most vital role in following up on workers in industrial plants. However, again it is national leadership which is required. Many industries with which we are now working have plants located in a number of states. Furthermore, there would not have been a national hypertension worksite program if it had not been for the impetus of a National Hypertension Worksite Conference sponsored by the Department of Health, Education and Welfare in 1976. This Conference sparked industry and labor into strong support of the present worksite program.

Our second big challenge is the intensive educational effort required to keep people in treatment. As an example, a person goes to his personal doctor or a community clinic and is detected as a hypertensive. He is put on a drug and told to report back in two months for a checkup. But the disease has no symptoms and he feels pretty good, so he doesn't continue the treatment. At the present time, we have been able to achieve long-term blood pressure control in only about one in five patients. In flat statistical terms, experts estimate that about 12 million Americans now have their blood pressure under control; the task is to get to the remaining 48 million people. We have a much better track record in industry, and that is where we are concentrating much of our effort now. In some industries, 80 percent of the employed population is in continuing treatment.

To overcome this drop-out syndrome, the National Heart Institute, the Health Services Administration and various medical organizations in the private sector have received enormous cooperation from the Advertising Council. Last year, for example, we had major television spots centering around the theme "Treat It For Life." These spots have featured Bob Hope, Danny Kaye, Ann Landers, Reggie Jackson, Ed Asner and many others. Bob Hope, our major television spokesman in both 1980 and 1981, constantly repeats the message that you have to stay in treatment for life to control high blood pressure. As he says in various TV spots: "Treat It For Life. It will mean a much longer life...more years to spend with your loved ones."

We are absolutely confident that many members of both parties in the Congress will battle to retain the hypertension project grant. Over the years, the program has been subject to thorough Congressional analysis. In August, 1980, the House Appropriations Committee, not generally known for throwing either money or compliments around, concluded that "if the program were expanded to reach additional millions of hypertensives not now being served, it would be possible to extend the lives of tens of thousands of Americans who die each year at an earlier age than they should...The decline in morbidity and mortality associated with hypertension may yield an economic return that can be measured in the billions."

Our hope for continuity is based to a considerable degree upon Secretary Schweiker. He certainly understands the necessity for strong national leadership to check a disease which crosses state lines and exceeds the technical ability of the states; his battle in the Congress for a National Diabetes Program is a classic example of this. As the ranking minority member of the Health and Scientific Research Subcommittee, he played a key role in every aspect of hypertension legislation. In a press conference several days after his designation as Secretary of the Department of Health and Human Services, he made this major pitch for preventive health care as a keystone in his administration of the Department:

"You are going to find a strong emphasis on preventive health care as a good way of holding down costs and cutting disease rates."

Mr. Chairman, I have included our appropriations recommendations in the one-page summary of our recommendations attached to this statement. The current budget for the hypertension project grants to the states in the Health Services Administration is $20 million. The Carter Administration request for Fiscal 1982 was $25,883,000. The Coalition for Health Funding, an amalgam of 62 national health organizations, held hearings on our program last December. It recommended $35 million for Fiscal 1982 as a starting sum toward the long-term goal of reaching 36 million hypertensives whose disease is not now under control.

We concur with the $35 million recommended by the Coalition for Health Funding.

SUMMARY RECOMMENDATIONS, HYPERTENSION PROJECT GRANTS TO THE STATES (HEALTH SERVICES ADMINISTRATION)

Blue Cross/Blue Shield, after a two-year study in a number of states, concluded in a report in 1980 that high blood pressure is "the most common adult chronic disease." According to figures from both the Health Services Administration and the National Heart Institute, 60 million Americans have high blood pressure. High blood pressure is the major factor in three-fourths of all first strokes and is a major factor in two-thirds of first heart attacks. The Public Services Laboratory of Georgetown University recently calculated that stroke and heart attack together cost this nation $50 billion a year.

Despite these startling figures, the hypertension project grant has had a long and hard struggle to obtain even minimal financing. The initial legislation creating the grant placed us in 314(d), and our first appropriation was only $3,500,000 for all 50 states. In 1978, we got out from under the 314(d) basket grant, largely due to the efforts of then-Senator Richard Schweiker. In both Fiscal 1980 and Fiscal 1981, we received only $20 million, far less than the original authorizations in the 1978 legislation.

In 1980, as required by the new law, the Surgeon General submitted a Prevention Profile Report to the President and the Congress. He proposed this realizable goal:

"By 1990, at least 60 percent of the estimated population having definite high blood pressure (160/95) should have attained successful long-term blood pressure control, i.e., a blood pressure at or below 140/90 for two or more years."

This goal requires that 36 million of the 60 million Americans who have high blood pressure be brought under successful long-term treatment in the decade of the eighties. To achieve this goal would require a large expansion of the program. Former President Carter recommended $25,883,000 for Fiscal 1982 as the first step in moving toward the goals of the Prevention Profile Report. The Coalition for Health Funding, an amalgam of 62 national health organizations, held hearings on our program last December and recommended $35 million as a minimum appropriation for Fiscal 1982.

The state hypertension coordinators, who carry the burden of achieving these objectives, have much higher sums in mind. As an illustration, here is a quotation from a recent newsletter from one of the state health departments: "It is our conviction that a funding level of $58 million in Fiscal 1982, $78 million in Fiscal 1983, and $98 million in Fiscal 1984 is a realistic estimate of what is needed to meet the new challenges."

We would like to recommend these figures, but we are aware of the present economic climate. We therefore recommend $35 million for the hypertension project grant program in Fiscal 1982.

Additional Comments

Mr. Chairman, I want to depart from the prepared text and be very frank with you. Our Board, from Dr. DeBakey on down, and thousands of physicians are convinced that we have created the first believable prevention program against a chronic disease. Dr. Robert Levy, Director of the National Heart Institute, has put it as well as anyone: "In high blood pressure, our nation's primary goal is PREVENTION. It is the only truly effective program. In seven short years, the program has become what it is today, probably the most exciting program of disease prevention. In that period of time, we have witnessed a miraculous drop of 38 percent in stroke deaths and 25 percent in heart attacks."

Despite these achievements, we have had a long and hard struggle to maintain our visibility and our connection with the mainstream of American medicine. Mr. Chairman, for years we were buried in 314(d), the basket grant to the states, which we view as one of the great legislative disasters of all time. Mainly through the efforts of then-Senator Schweiker, we got out of 314(d) and were on our own for a short while. Now we find ourselves in a block grant with a bunch of Centers for Disease Control programs. This really dismays us. Last year, the Carter Administration tried its darndest to transfer us to the Centers for Disease Control. We barely managed to escape, and now it looks like another struggle to stay out of the Centers for Disease Control, whose track record in prevention has never set the world on fire.

Mr. Chairman, we know where we belong, and we have been trying to get there for years. We want to be an out-reach arm of the National Heart Institute, which has the expertise we need. The National Heart Institute conducts approximately $75 million worth of research each year into the terribly difficult problem of hypertension. It, and the pharmaceutical houses of this country, have come up with basic research findings leading to more than 25 effective anti-hypertensive drugs. The problem is that, like most of the National Institutes of Health, the heavy emphasis on basic and clinical research seems to relegate a strong prevention offensive to a rather low priority. That is where we come in.

We can provide this prevention know-how, and our network of hypertension coordinators in the 50 states has developed the educational and communication skills which can bring these reseach advances to millions of people in need. Why haven't we been part of the National Heart Institute before? The answer: Bureaucracy and turf. In 1979, a report to this very Committee pointed out it was inexcusable that the research part of our high blood pressure effort was separated from the prevention delivery part. The report severely criticized the lack of coordination between the Health Services Administration and the Heart Institute, but nothing was really done. Bureaucracy marches on.

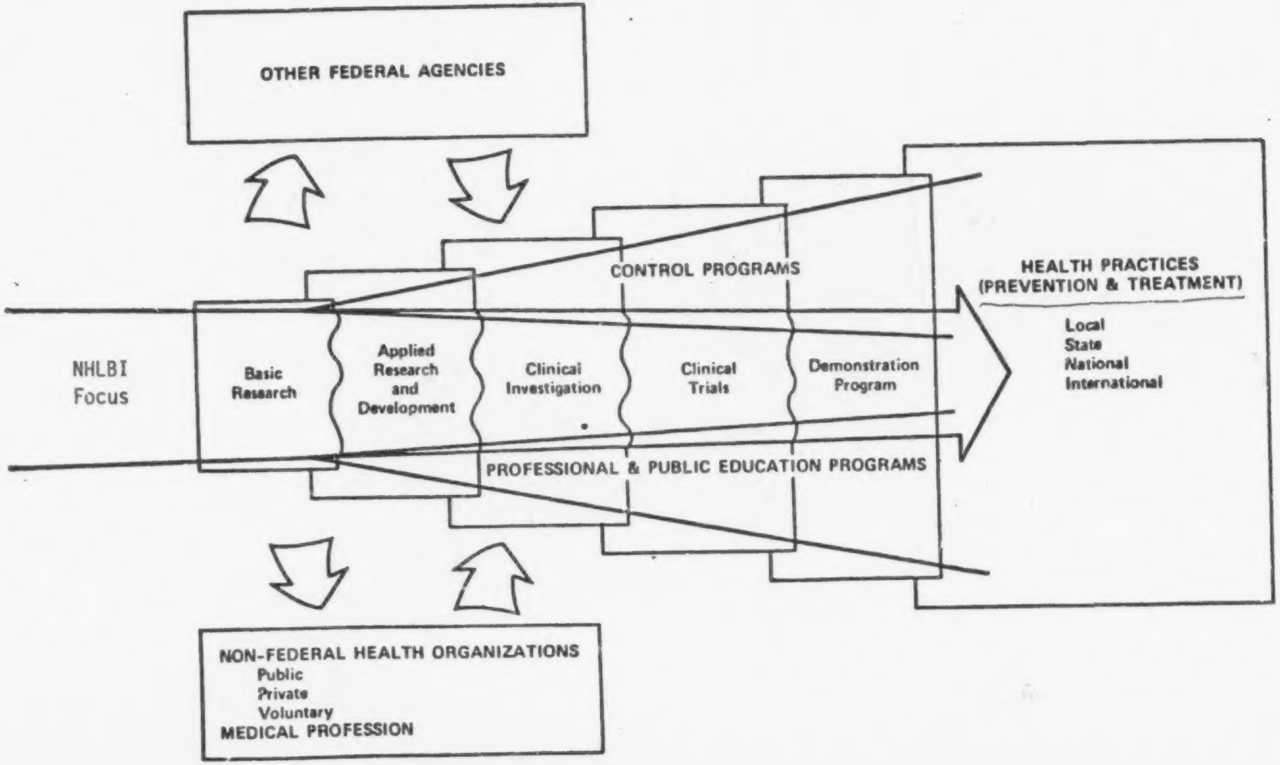
Mr. Chairman, I realize that this is not a legislative committee, but you and I know that it has a tremendous impact on the direction which programs take. Surely we need an adequate appropriation, but we must be in the proper agency to make maximum use of every dollar you give us.

May I plead with you to support legislation currently being drafted - a simple amendment to Title IV, transferring our program to that authority. The present thought is that the legislation could be even more specific. Title IV deals with the authorizations for the National Institutes of Health; section 414, under the National Heart, Lung and Blood Institute authority, deals with the prevention, control and education activities of the Institute - in other words, the application of research findings to the prevention of disease. This is where we belong. We would merely add another section 414 authorizing a two-year extension of the hypertension grants to the states at a modest level of $25 million in Fiscal 1982 and $30 million in Fiscal 1983. In any case, we definitely want reauthorization by May 15 so that we can be sure of funding for Fiscal 1982.

Then, finally, basic research and applied prevention - guaranteeing that the newest findings from the laboratory are expeditiously transmitted to the bedside, the clinic and the practicing physician - would establish a unified attack against America's most common chronic disease.

Mr. Chairman, it is apparent that this statement has been drawn up in haste. In fact, it was finalized yesterday. We received the Administration proposals in this area less than a week ago. I therefore respectfully request the opportunity to submit a supplemental statement after the Board of Citizens for the Treatment of High Blood Pressure has an opportunity for another meeting and further discussion of the issues.

FLOW CHART
RESEARCH TO APPLICATION


OTHER FEDERAL AGENCIES
NHLBI Focus
Basic Research
Applied Research and Development
Clinical Investigation
Clinical Trials
Demonstration Program
CONTROL PROGRAMS
PROFESSIONAL & PUBLIC EDUCATION PROGRAMS
HEALTH PRACTICES (PREVENTION & TREATMENT)
Local
State
National
International
NON-FEDERAL HEALTH ORGANIZATIONS
Public
Private
Voluntary
MEDICAL PROFESSION

STATEMENT OF WENDY J. WERTHEIMER, DIRECTOR, BIOMEDICAL RESEARCH AND PUBLIC POLICY, AMERICAN SOCIAL HEALTH ASSOCIATION

Senator SCHMITT. The next panel which we are going to cut back to 4 minutes—nobody seems to be able to live within the time limit. The three members are: Wendy J. Wertheimer, Director of Biomedical Research and Public Policy, American Social Health Association; Dr. Marcus M. Key, Professor, Occupational Medicine, Association of University Programs in Occupational Health and Safety; Dr. Gertrude Engel, Executive Director of Save the United States Movement. Your prepared statements will be printed in their entirety after your oral presentations.

Ms. Wertheimer, please.

I have to reset the clock. When the yellow light comes on, you will have 3 minutes left for your presentation.

Ms. WERTHEIMER. Mr. Chairman, I am Wendy Wertheimer, and I am director of public policy and biomedical research in the American Social Health Association. ASHA has been in existence since 1912 and is the only national nonprofit agency totally dedicated to the control of venereal disease.

Certainly, no issue confronting this committee is so fraught with myth and social stigma and misinformation as the issue of venereal disease. Although it has been around since biblical days, it continues to be shut in the closet, and there is a real concern about talking about it.

I would like to dispel just a couple of those myths right now. One is, "people with venereal disease deserve it." That seems to be a pretty common underlying thought, and I think when you understand that more babies this year will be affected by venereal disease than children who got polio during the entire polio epidemic, you can hardly say that these babies who are the victims, deserve it.

The second myth is that "once we find good antibiotics, we can control the venereal disease problem." Again, that is not true.

A lot of diseases today have become resistant to penicillin—that's such a good antibiotic.

The other problem with venereal disease, there are new diseases which in no way are controllable by antibiotics. Herpes affects 20 million Americans, and that is a low estimate. Herpes is incurable, it is uncontrollable, and it is causing serious medical problems.

There are other venereal diseases which we never even knew were sexually transmissible until the last couple of years, which are now at least twice as prevalent as gonorrhea. NGU is causing sterility in men and in women and is harming seriously infants of women.

Venereal diseases are causing ectopic pregnancies, which as you know always means the death of the fetus, and often maternal death.

And, they are causing other problems in women. Herpes is known to have an association with cervical cancer. Women who have herpes have 10 times greater chance of developing cancer.

These are issues that can no longer be thrown under a carpet and ignored—10 million cases of VD occur every year. There are 20 million people at least a year with herpes. One out of every seven teenagers in this Nation has a venereal disease.

There are three points that I would like to make: One is, although it seems to be unpatriotic for a Federal program, this program works. It is cost effective. You can show—as one of my charts shows in my testimony—that when Federal dollars go up—which they don't very often, they have in the last few years—incidence goes down. It is actually starting to come down.

Another consideration that has to be made is that there is interstate transmission of the diseases. They are, after all, communicable diseases. And, if Nevada is doing a good job, but New Mexico is doing a lousy job—or another State is doing—these people are going back and forth and one State is going to seriously harm the rest of the country.

I think that the only thing that we can say to you is that again we, like everybody else, are in the block grant and we have the same reasons everybody else has for not wanting to be in the block grant.

The interstate transmission problem, I think, is the most serious one, however. There has to be uniform excellence throughout the country or the weakest links really will harm them all.

And we have recommended the $5 million increase for the program which I think is only justifiable. If you look at past epidemics of legionnaires disease, of polio, swine flu, and you see how this Nation rallied to do something about that problem, and you look at the fact that VD has gone on forever and it is getting worse and worse and worse. Yet there is no similar outcry, no alarm, and no effort to really put an end to it. It doesn't balance out against other problems that we have and this country has been able to control.

Thank you.

Senator SCHMITT. Thank you very much.

Next, Dr. Marcus M. Key, professor of medicine with the Association of University Programs in Occupational Health and Safety.

STATEMENT OF DR. MARCUS M. KEY, PROFESSOR, OCCUPATIONAL MEDICINE, ASSOCIATION OF UNIVERSITY PROGRAMS IN OCCUPATIONAL HEALTH AND SAFETY

Dr. KEY. Thank you.

In addition to my prepared statement, I would like to make the following remarks.

The credibility of the Federal Government is at stake in regards to health manpower development programs in general. and occupational safety and health in particular.

A number of universities have developed programs to alleviate the tremendous shortages in occupational safety and health manpower, and many students have enrolled in these programs with the expectation of pursuing successful careers in the preventive health professions of industrial hygiene, industrial safety, occupational health nursing, occupational medicine, industrial toxicology.

An excellent beginning has been made over the past 4 years. The very large deficits in manpower present when the Occupational Safety and Health Act passed, are being reduced. And now, all of a sudden, manpower development and training grants in occupational safety and health are being wiped out at the Federal level.

This includes NIOSH's excellent Division of Training and Manpower Development. It includes the 12 educational resource centers funded by NIOSH on a regional basis. And also includes 13 project grants at other universities.

Except for remnants of the programs that may be able to survive at a few universities, there will be no facilities for developing manpower in the field of occupational safety and health. Moreover, the research and community services these centers have been providing, must also be reduced or curtailed.

The most serious impact will, of course, be on the students in these programs. And also on the industry, labor unions, and the Government agencies that utilize the professional outputs of these programs in controlling and preventing occupational safety and health problems.

Ultimately, it is the American worker who is going to suffer the most.

I recognize that the universities should increase their dollar commitment to occupational safety and health programs as the Federal dollar decreases. And this was one of the guidelines for an extension of the NIOSH educational resource center grant program.

But, to terminate the educational resource center grants abrubtly—the project grants also during this fiscal year, is like pulling the plug on a life support system before the patient is able to fend for itself.

I would urge you to restore the cuts to the NIOSH budget in fiscal years 1981 and 1982 back to the level of $15 million, and also positions. NIOSH is facing a serious reduction in force unless most of its positions are restored.

Thank you.

Senator SCHMITT. Thank you very much.

Next, Gertrude Engel, Executive Director of Save the United States Movement.

STATEMENT OF GERTRUDE ENGEL, EXECUTIVE DIRECTOR, SAVE THE UNITED STATES MOVEMENT

Ms. ENGEL. Senator Schmitt, it is indeed an honor to be here. I also represent the National Health Federation. We are kindred spirits—you, as a former astronaut on Apollo 17—this is my lucky day. It is raining today. It was lucky for you that day when they said you would not take off for the simple reason that there was an electrical storm at the Cape. And I told NASA officials that it would not rain anymore that afternoon, and you lifted off. So I'm hoping we can get the same courtesy here.

I love the idea of your gracious manner.

You know, you were wonderful to Dr. Foege, and I love him, too. But I will tell you he is very wrong when it comes to saying that cancer is not caused by fluoridation in the drinking water. He told you there is no evidence of it and my heart dropped out of its socket.

And of course, after the meeting I corrected him. I asked him why he continued on to do what he was doing, because he was not alerted to the many happenings within the States. And when you asked him if it would be possible to have local communities take this on, he said no because he said they needed the guidance of the Center for Disease Control, which is an error for this reason:

He did not know that in Orange County, Calif., just recently, after a meeting which began at 9 in the morning and ended at 3 o'clock the following morning with 29 witnesses, they turned back $500,000 to the Center for Disease Control and said, "Thank you very much, we don't need it. We don't intend to fluoridate the water."

What we need is education in proper nutrition. The Dental Association seems to differ with me on this, and if we eat our apples every day—fruit and vegetables—which I understand has all the fluorides anyone past the age of 12 needs.

We are asking if you will please delete the appropriation because I said to Dr. Foege, if you feel that you don't know all the answers to the various facts dealing with fluoridation, why do you continue to ask for a 10-year appropriation, and then after 10 years he told you he wouldn't bother with us again. Foege answered, "I am really not pushing this."

To which I asked, "Why bother at all?"

Now, I want to show you in this little cap wherein I did a scientific research. In the concave of a bottle that I used, the same substance appeared. I do not drink the water here in Washington, and I am advising everybody else not to either—drink distilled water if you want to save your life. This cap was filled with all the contamination. You see a little bit of it left, because I have carried it around to the different conventions where I appear to give my lecture on fluoridation and proper nutrition.

I put the bottle next to the refrigerator, and I waited a week to see what would happen. In the concave of the cap, and also in the bottle, the contents turned out to be the contamination which you see. This is what we are drinking here in Washington. And here it is. I've got a little bit of it left, because every time I show it to somebody else, more of it drops out.

Recently in Houston, Tex., also, $1,389,880 was offered by the Center for Disease Control to add fluoridation to the water.

The Houston court undertook the case on December 2, to prevent flouridation—ruled against it and the case was appealed. And on February 16, another judge did exactly the same. He ruled with the first judge to prevent fluoridation in the water.

Under the leadership of Martha Bevis, 700 citizens—which I thought was an absolute accomplishment—formed a citizens' committee, each one signed a power of attorney and presented their findings to the court, "not to have fluoridation in Houston, Tex."

Alton, Ill., is now waiting for the judge's decision.

Five cities in Arkansas have voted against fluoridation.

Wichita, Kans., just came down with their theory, no fluoridation for them.

This is the way it is going nationwide. As long as we have it this way, is it possible that we delete the appropriations and let the local communities make their decision.

We thank you.

Senator SCHMITT. Thank you, very much. Thank you, panel.

[The statements follow:]

STATEMENT OF WENDY J. WERTHEIMER

On behalf of the Board of Directors of the American Social Health Association, the only national non-profit health organization solely dedicated to the prevention, control and eventual elimination of venereal diseases, I thank the Subcommittee for this opportunity to present testimony on the fiscal year 1982 appropriations bill.

The American Social Health Association has served the nation since 1912, and provides the following services and programs: The Venereal Diseases Research Fund, which provides postdoctoral research training fellowships for sexually transmitted disease investigation; the VD National Hotline, which last year provided toll-free 24-hour venereal disease information and referral to more than 120,000 callers in its first year of operation; HELP, the only program in the nation providing information and support to the millions of sufferers of herpes simplex virus diseases; and professional and public information programs.

Mr. Chairman, it can be conservatively estimated that at least 10 million Americans will contract a venereal disease this year. The Department of Health and Human Services estimates that 33 percent of these cases will be among teenagers, 86 percent among young people 15 to 29 years old. This translates to an attack rate of one out of every seven teenagers infected with a venereal disease.

Aside from the major acute emotional and medical difficulties experienced by most of these victims, the most compelling tragedy is the fact that 100,000 women will be left pathologically sterile by these diseases this year, 50,000 of those women under the age of 25. Today VD is the single greatest cause of unintended sterility of women of child-bearing age. More than 20 million Americans (some estimates are as high as 40 million) today suffer from a painful, recurring and incurable venereal disease called herpes simplex type 2. Within the last three years it has been learned that another sexually transmitted disease, called nongonococcal urethritis (NGU), is at least twice as prevalent as gonorrhea and is having devastating medical consequences in men, women, and newborn babies.

These are staggering statistics. Outbreaks, or threatened outbreaks, of other diseases, such as Legionnaire's disease, swine flu, and polio have been met, appropriately, by governmental initiatives and public support. But this has never been the case with venereal diseases, which remain shrouded in myth, social stigma, and misinformation. The program of venereal disease control has experienced a roller-coaster of funding historically.

Until 1972 the federal program to control VD consisted solely of a syphilis program. Since 1972, the program has had the added focus of gonorrhea control. Despite constant fluctuations in funding levels, this program is one which can be proven cost-effective. As Chart 1 attached clearly shows, when federal dollars have been increased to the venereal disease program, the incidence of venereal disease has decreased. However, when the government has been complacent or cut back its commitment to the program, incidence has risen.

In fiscal year 1980 the venereal disease program received a funding increase, which has successfully brought down the rates of syphilis and gonorrhea. It is clear, however, that the 25% cut proposed by the President's budget would once again result in higher rates of disease. The effect of this cut will be made even more severe by proposed cuts in the Medicaid program, which will put increased demand on public health clinics. These clinics are already over-flowing, and the reduced options for care which will now be available for the "near poor" will place far greater burden on the public health system.

Perhaps one of the most cogent arguments for the cost-effectiveness of the venereal disease program is the fact that this relatively small program last year provided direct venereal disease control and prevention services to more than 9,300,000 Americans. The number of people who have benefitted from the program's education, information, and applied research efforts cannot be estimated, but these initiatives certainly have been of great value to the entire nation. As Chart 2 shows, no state is immune from the problems and consequences of these diseases, and the need and demand for information nationwide has been tremendous.

A new initiative begun by the venereal disease program in fiscal year 1980 has provided a valuable new dimension in venereal disease control efforts by directing attention on the consequences of the diseases as well as the diseases themselves. The new initiative is aimed at detecting and treating pelvic inflammatory disease, a common consequence of several sexually transmitted conditions. PID is a painful condition, estimated to affect 10 to 20 percent of women with gonococcal infection, and which, even when treated, can result in recurrent salpingitis, ectopic pregnancy, and infertility, often requiring surgical removal of reproductive organs.

As mentioned, the control program has focused almost exclusively on syphilis and gonorrhea with its very limited funding. It is now known, however, that at least 20 diseases are sexually transmitted. This new generation of diseases poses new problems and new threat to the public health of this nation. Genital herpes is an incurable virus which claims more than 20 million Americans as its victims, and these victims remain infected throughout life. Incurable and unpreventable, and hence not subject to control in any sense, the reservoir of persons who are plagued with this disease could easily double or triple in the next few years. Aside from the concern over the sheer magnitude of this problem, there are some severe medical consequences. Herpes can seriously endanger a fetus during birth, causing serious neonatal disease or death. The disease may also be responsible for miscarriage or stillbirth. Of infants who contract the disease, roughly two-thirds die. The long-term consequences of herpes infection have also been linked to carcinoma of the cervix, with cancer occurring as much as ten times more frequently among women with herpes than among uninfected women. The virus can be inadvertently transmitted into the eyes, and in fact, is the most frequent cause of infectious blindness in the United States today.

Another new concern is Chlamydia Trachomatis infections, which have only been recognized as a major public health threat in the past two years. The organism causes nongonococcal urethritis (NGU) in men, which we now know is several times more common than gonorrhea, and is potentially sterilizing.

Chlamydia produces serious complications in women, as well, including tubal infection (PID). There are also important implications for newborns, as chlamydia is the most frequent cause of infant eye infection and pneumonia, and the organism has been implicated as an agent in Sudden Infant Death Syndrome. Diagnosis for chlamydia infection is expensive and not yet readily available. Thus, many infections go without appropriate treatment. NGU is now the most common venereal disease among college students and among young people, having become firmly entrenched in the upper ranges of the socio-economic scale.

The Administration's proposed inclusion of the venereal disease program in a preventive health block grant to states in addition to the large cut in funding will create a dangerous public health situation in this nation. The unpopularity of the issue in a mix of other initiatives would make it very difficult for the venereal disease program to compete for funds. Competing unfavorably for drastically reduced funds in the states will leave the control program for venereal disease in a shambles.

What must be pointed out most importantly about this program is that these diseases are, first and foremost, communicable diseases. American society is incredibly mobile. If one state is doing a poor job of VD control, every state will suffer because of the high degree of interstate transmission of disease. Chart 3 (attached) highlights a recent problem of an outbreak of penicillin-resistant gonorrhea which originated in California, but which rapidly became a national problem. It is crucial that the program have a uniformity of strength and excellence in each state with strong national coordination. The interactive relationship among states is critical to national control of the diseases.

Another vital component of the prevention and control program is the cadre of CDC-trained public health advisors who assist and advise state VD programs and help train personnel in the states. These advisors represent years of training and experience which could never be developed state-by-state. We strongly support the provision in the President's budget which would permit the continuation of this important element of the program.

We also support the President's intention to maintain a strong national office which carries out critical and unique functions of clinical research, education, epidemiology, and national monitoring.

However, we urge the committee not to back away from progress made over the past few years. Categorical funding for project grants in venereal disease prevention and control must be maintained for the good of every state. History has proven that VD is still very much viewed as a repugnant issue, and if left once again to the states to initiate control and prevention, the problem will again be buried, resulting in an epidemic of untold proportions.

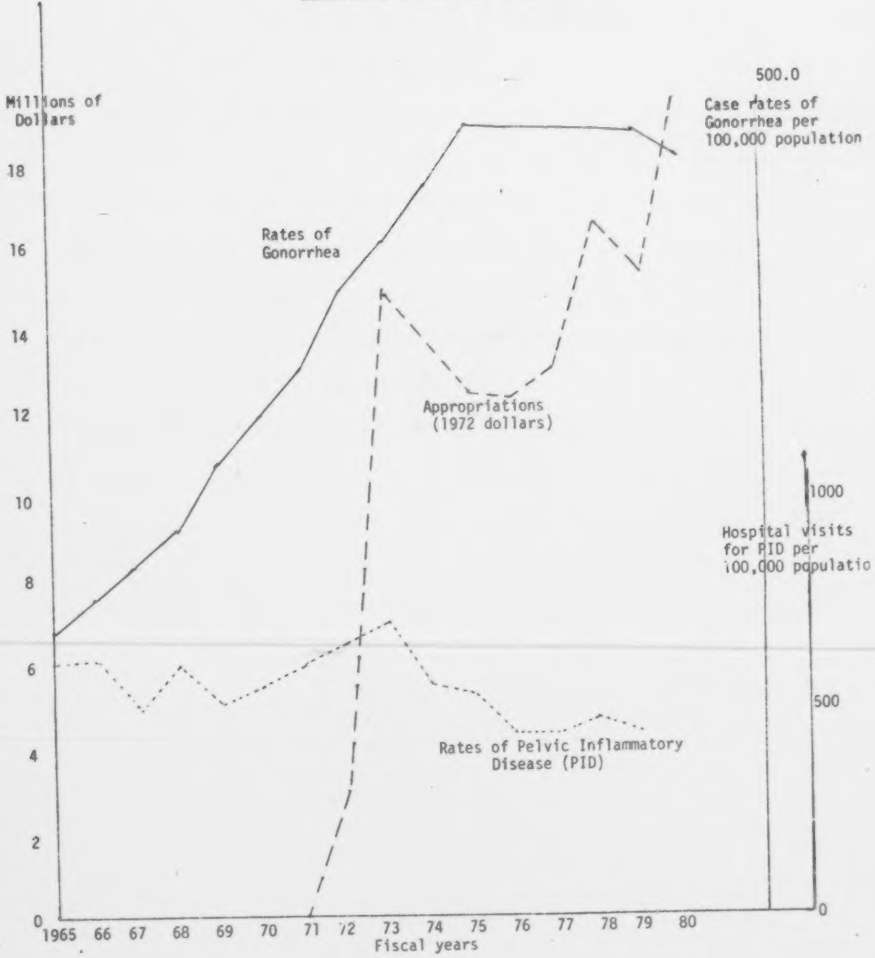
We recognize the need for a streamlined federal budget. But it must not be forgotten that there are functions of the federal government which are unique to it -- and which do work and are cost-effective. These programs must be maintained and strengthened. Sacrifices can and must be made, but the sacrifice of the public health is an inappropriate place to start. We recommend an increase of $5 million for the Venereal Disease Prevention and Control Program, which we believe is a rational, justified, and wholly appropriate and necessary step for this committee to take.

Thank you for this opportunity to present our views.

CHART 1

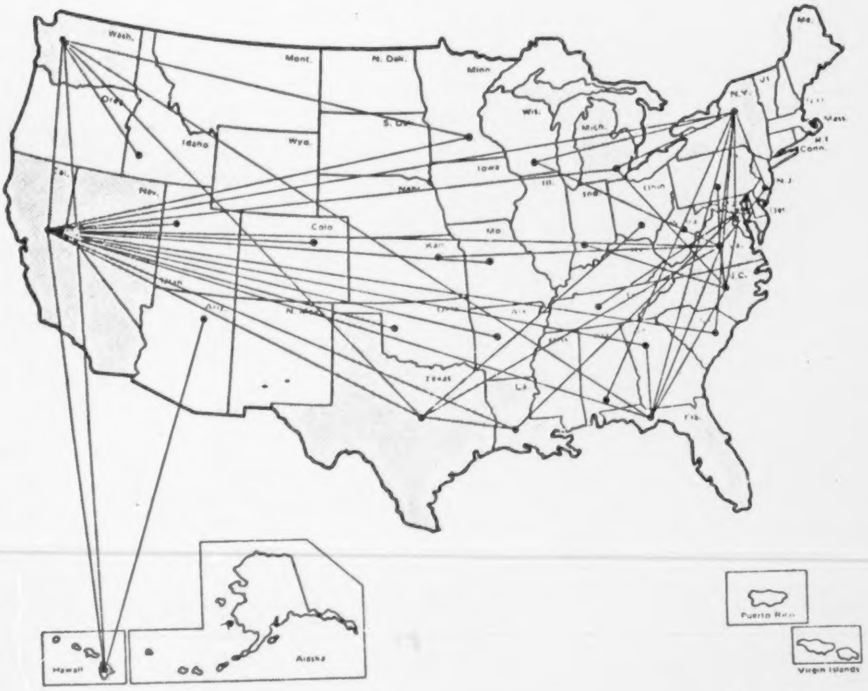
FEDERAL PROJECT GRANTS TO STATES FOR GONORRHEA CONTROL

FEDERAL APPROPRIATIONS FOR VD PROJECT GRANTS
VS
GONORRHEA CASES AND PID VISITS



CONTROLLING PENICILLINASE-PRODUCING NEISSERIA GONORRHOEAE

CHART 3


Wash.
Mont.
N. Dak.
Minn.
Me.
Vt.
N.Y.
Mass.
Oreg.
Idaho
Wyo.
S. Dak.
Wis.
Mich.
Conn.
Cal.
Nev.
Iowa
Ill.
Ind.
Ohio
N.J.
Nebr.
Colo.
Mo.
Kans.
Del.
Utah
N.C.
Ariz.
N. Mex.
Texas
La.
Fla.
Hawaii
Alaska
Puerto Rico
Virgin Islands

TWELVE (12) STATES EXCHANGED CRITICAL INFORMATION ON 137 PPNG CONTACTS WITH 30 DIFFERENT STATES AND THE DISTRICT OF COLUMBIA.

CHART 2

VENEREAL DISEASE PROFILES OF STATES

STATE	VD NAT'L HOTLINE CALLS RECEIVED 1980	VD and HERPES LETTERS RECEIVED 1980	REPORTED VD INCIDENCE 1979
Alabama	616	1,857	25,919
Arizona	966	3,200	11,787
Arkansas	240	868	10,897
California	6,602	43,606	144,829
Colorado	616	5,097	11,120
Connecticut	1,128	2,402	10,035
Delaware	456	293	4,004
District of Columbia	758	1,736	17,709
Florida	1,832	13,021	66,004
Georgia	772	3,866	48,037
Idaho	118	727	1,806
Illinois	3,512	8,711	57,878
Indiana	1,002	2,635	17,413
Iowa	422	1,252	5,975
Kansas	388	1,736	8,867
Kentucky	450	1,383	11,922
Louisiana	762	2,836	25,938
Maine	300	787	1,804
Maryland	936	3,230	30,441
Massachusetts	1,566	4,703	10,710
Michigan	1,668	6,450	37,884
Minnesota	516	3,866	8,453
Mississippi	404	727	18,958
Missouri	918	2,836	22,356
Montana	298	656	1,959
Nebraska	392	898	3,631
Nevada	190	1,231	6,504
New Hampshire	156	636	954
New Jersey	3,282	5,027	21,485
New Mexico	240	1,091	5,098
New York	6,720	16,786	68,803
North Carolina	380	3,230	36,513
North Dakota	94	242	849
Ohio	2,554	5,713	43,573
Oklahoma	624	1,837	13,159
Oregon	462	4,007	10,633
Pennsylvania	2,006	6,521	29,929
Rhode Island	276	636	2,040
South Carolina	736	1,554	22,929
South Dakota	58	232	1,608
Tennessee	1,092	2,392	32,179
Texas	3,806	11,235	88,131
Utah	274	686	2,056
Vermont	82	575	657
Virginia	1,712	4,663	24,561
Washington	906	6,157	15,146
West Virginia	250	818	3,989
Wisconsin	1,192	2,372	14,491
Wyoming	66	394	1,159

Excluded are Alaska and Hawaii, which are not served by the VD National Hotline
Reported VD = Syphilis and Gonorrhea only. Herpes, NGU, Trichomoniasis, etc. not included

STATEMENT OF DR. MARCUS M. KEY

The Association of University Programs in Occupational Health and Safety supports the NIOSH budget at a $83 million level for Fiscal Years 1981 and 1982 and NIOSH's Training Grant Program at a level of $14.3 million in Fiscal Year 1981 and $15 million in 1982.

In this decade of the Eighties, when preventive medical programs should be promoted and encouraged, one of the primary impediments is the inadequate supply of occupational safety and health manpower--a prediction made at the time the Occupational Safety and Health Act was passed. The most significant development in occupational safety and health in the last decade has been the NIOSH Educational Resource Center Program, in which a number of the leading universities have mounted interdisciplinary, graduate, training programs on a regional basis in occupational medicine, occupational health nursing, industrial hygiene, industrial safety, and other disciplines. There has been a broad based community support from both labor and industry, and the graduates are much in demand for service in government agencies, colleges and universities, industry, and the labor movement. A recent review of this program by a national peer review group concluded that the program has been effective in

--increasing the visibility of occupational safety and health nationally
--increasing the academic recognition and stature of the field
--pooling occupational safety and health resources
--establishing a focus for research and service activities
--attracting and hiring qualified faculty
--recruiting high calibre students
--influencing the career choices of students toward this field
--creating a critical mass of leaders in the various occupational disciplines

The NIOSH Educational Resource Center Program is a timely and prudent investment for the Federal Government because

(1) The Centers are turning out significant numbers of highly qualified professionals to cope with the myriad chemical and physical problems in the workplace. Moreover, these professionals receive interdisciplinary training which increases their ability to solve complex problems and encourages them to work together as a team.

(2) The manpower deficits in occupational safety and health are still with us and will be so for some time.

(3) Although there is a strong demand by students for undergraduate and graduate programs in occupational safety and health, and a phenomenal job market for graduates of these programs, universities have been slow to reprogram or reallocate faculty positions. The NIOSH Training Grant Program permits an orderly change in the funding of these programs to take place.

(4) The State-supported universities and the private universities are really hard pressed for money and with some state legislatures meeting every other year, the lead time for converting to state support can be several years.

(5) With anticipated termination of Federal capitation grants for Schools of Public Health, these schools are going to even more hard put to fund existing programs.

(6) For physicians going into the academic year of a residency program in occupational medicine, there is no other means of support.

(7) There is a great deal of community support for the Educational Resource Centers. Labor and management both benefit and will so attest in each of the regions where Centers are located.

STATEMENT OF GERTRUDE ENGEL

Mr. Chairman and the illustrious members of the Appropriations Committee.

My name is Gertrude Engel. I am the executive director of Save the United States Movement dedicated to health practices, founder and national chairman, Bob Hofman, Ph.D., of York, Pennsylvania; and represent the National Health Federation based in Monrovia, California.

It is indeed a privilege to be here and I thank you sincerely for the honor.

We humbly request, please, that the appropriation in the proposed budget for FY 1982, to the Center for Disease Control, incidental to water fluoridation be rejected; and the $6.8 million FY1981 be deleted

What is water fluoridation?

It is the controlled adjustment of a water supply for a concentration of about one part of the fluoride ion in a million parts of water or 1/10,000 of one percent fluorides in water.

The fluoride ion is a chemical element that occurs in the environment of man, in soil, vegetation and water. Trace amounts are present in air. Fluoride is found in varied amounts in nearly all regions of the entire world. Nearly all food items contain some fluoride. To totally avoid intake of fluoride in food, you literally would have to starve to death.

Fluoridation does not effect the taste, the odor or the color of water in its use for any cosmetic or industrial purposes. Hardness of the water has no effect. One hundred five million people in America drink fluoridated water. How unfortunate!

Flourine (in the form of fluoride) is classified by the National Academy of Sciences as an essential trace element which can be toxic in excessive quantities. At high concentration, fluoride has been used as a poison for insects and rodents.

The Food and Drug Administration admits that fluoride is not listed on the Generally Recognized as Safe (GRAS) list. It is a toxic material. It is a regulated food additive and must have clearance for dosage and is subject to safety and usage information.

Fluoride is still classified as a schedule "A" poison in the State of California.

Fluoridation ranks as one of the most controversial health issues of recent time.

We feature Dr. George L. Waldbott, who is the author of four books, the latest 1979 (Fluoridation: The Great Dilemma). He is also the author of about 250 articles and 150 papers.

He comments, "The American Dental Association considers the subject of fluoridation undebatable. During my more than 50 years of medical practice and experience with about 40,000 allergic patients, a speciality which constantly requires detection of causative agents, I have contributed materially to the advance of knowledge on the clinical phase of allergy and environmental health.

"Fluoride, can accumulate in, and effect, any organ of the body causing a wide variety of symptoms. I am convinced that fluoride causes cancer. In relating my experiences, I can speak with authority of the direct poisoning from fluoridated water and other side effects. For instance, children suffering with stomach upsets, headaches and other multiple illnesses."

Dr. Waldbott believes that doctors are not alerted to early signs of fluoride poisoning.

"On November 29 and 30, 1979, I personally interviewed 103 individuals poisoned by fluoride in Annapolis, Maryland, where through the negligence of an employee at the local water works, up to 36 ppm of fluoride was found in the municipal water supply instead of the designated 1 ppm. According to a conservative estimate, more than 4000 persons suffered adverse effects of fluoride. Whereas in most cases the disease was of short duration it is impossible to predict whether or not any permanent damage ensued to some of the victims, especially the elderly, to thoseprone to disease and to unborn babies of some pregnant at that time. Three other similar, less extensive, episodes of poisoning due to overfluoridation are on record."

Albert Burgstahler, Ph.D., Professor of Chemistry, The University of Kansas, Lawrence, Kansas, quoted in 1965 as President of the International Society for Fluoride Research, "A number of prominent scientists have argued that more ought to be known about the long-term consequences of drinking fluoridated water before people drink it daily. Abnormally high organ-damaging levels of fluoride have been found in the bones of persons with kidney dysfunction."

Most recently, in the State of Kansas, Dr. Burgstahler presented testimony in opposition to a bill, which was defeated in committee, that would have authorized statewide mandatory fluoridation.

"Since healthy decay-free teeth are found even where very little fluoride is consumed , the claim that fluoride is essential because it helps prevent dental caries is not convincing. Rather, tooth decay in today's society is primarily the result of diets overburdened with refined carbohydrates, especially sugar. Such diets are often also lacking in adequate amounts of the major tooth-building minerals - calcium and magnesium - as well as certain other known essential nutrients such as vitamin B-6 and other factors.

"Illness from fluoride includessuch familiar ailments as the following: migraine; epigastric distress; spastic colitis and ileitis, arthritic pain, especially in the lower spine; paresthesias in the arms and legs; visual distonbances involving the retina; and frequent episodes of pyelitis, polydipsia,polyuria, and various types of skin disorders.

"Finally, there is unrefuted evidence that fluoridation is associated with an increase in cancer mortality, at least in the ten largest fluoridated U. S. cities. In new work involving data on actual age-group-specific cancer death rates, not hypothetical, extrapolated standard mortality ratio calculations, the increase in cancer death rate among persons age 45 and over in the 10 largest fluoridated U. S. cities has been shown to be significantly higher since the start of fluoridation, compared to the ten largest nonfluoridated cities with similar cancer death rates in 1944-1950.

"Despite whatever reduction in tooth decay can be achieved by fluoridation, there is steadily growing amount of solid evidence showing that fluoride in drinking water at the officially recommended concentration of 0.7 to 1.2 ppm causes serious harmful effects in its users."

"The plain fact that fluorine is an insidious poison harmful, toxic, and cumulative in its effects, even when ingested in minimal amounts, will remain unchanged no matter how many times, it will be repeated in print that fluoridation of the water supply is 'safe'." Ludwik Gross, M.D. former Chief of Cancer Research of the Veterans Administration, Bronx, New York.

Quotes and comments from highly qualified scientists, eminent university professors and professionals:

"I am appalled at the using of water as a vehicle for drugs. Fluoride is a corrosive poison that will produce serious effects on a long range basis. " CHARLES GORDON HEYD., Former President of the American Medical Association.

"Never in the history of water supply has a substance with so much unfavorable evidence been considered seriously for introduction into the potable water of communities." BENJAMIN NESIN, Former Director of Laboratories, New York City Department of Water Supply. The late Mr. Nesin was an international authority on water supply and had served the City of New York for 35 years.

"It is unnecessary and unwise to wastefully add it (fluoride) to community water supplies for the following cogent reasons: Dosage is highly variable and inaccurate. Older children and adults do not need and should not be dosed with the drug." C. W. BLACK, M.D., Pediatrician, San Diego, California (Editorial: American Journal of Diseases of Children, August, 1963.)

"I am opposed on principle to the deliberate addition of any substance whatever to the public water supply with the avowed intention of influencing any physiological function of the human body." SIR STANTON HICKS, M.D. Ph.D., Emeritus Professor of Human Physiology and Pharmacology, University of Adelaide, Australia.

"Various kinds of health hazards have been overlooked or concealed concerning the biological effects of fluoride taken in the body even at the level of optimal concentration in the drinking water established by the Government." KOSEI TAKAHASHI, M. D. Emeritus Associate Professor of Medicine and Physical Therapy, University of Tokyo, Japan.

Fluoridation is most unethical and constitutes a potential hazard to the health and lives of many millions of people, especially children, to force them against their will to ingest fluorides daily in their drinking water, or in other vehicles, over very long periods. Not fluorine deficiency but deficient diets are the most important single cause of dental decay." DOUW STEYN, D.M.V. Emeritus Professor of Pharmacology, University of Pretoria, South Africa.

"In the large scale fluoridation experiments that have been or are now being conducted , variable doses of one of the most toxic substances are indiscriminately administered daily to all individuals in selected communities over long periods of time." PROF. ALBERT SCHATZ, Ph.D. F.R.S.H. Temple University

NOTE: NATIONAL FLUORIDATION NEWS * FLASH ANNOUNCEMENT
FLUORIDATION ENDS IN CHILE. THE FINAL STRAW that broke the back of fluoridation in Chile was a lengthy anddetailed report that Dr. Schatz published in 1976. "Fluoridation did not prevent caries but merely delayed the appearance of tooth decay. His reports presented evidence that fluoridation is not safe, especially for malnourished people. Such individuals make up the overwhelming majority of the population in all Latin American countries except Cuba. "An individual's nutritional state can markedly influence his susceptibility to fluoride toxicity.

"The Assembly and House of Delegates condemn the addition of any substance to public water supplies for the purpose of affecting the the bodies or bodily or mental functions of the consumers." Resolution adopted without a dissenting vote on April 12, 1958 and since re-affirmed by the ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS.

"No national primary drinking water regulation may require the addition of any substance for preventive health care purposes unrelated to contamination of drinking water." Par.6 Sec. 141s (b) of the 1974 Federal SAFE DRINKING WATER ACT (PL 93-523).

"Fluoridation has been linked to an increase in cancer in the artificially fluoridated cities as compared to non-fluoridated cities. Put your emphasis on good nutrition instead of fluoride chemicals that are dangerous enough to kill a three-year-old child in a careless moment in a dental clinic recently when using fluoride as a topical "preventative" treatment. The Court awarded the parents $750,000. A much needed improvement in general health through good nutrition was displaced by one part of fluoride in a million parts of water." ALLEN LONDON, D.D.S. Boonton, New Jersey.

"Fluoride is a carcinogen! An historic legal decision handed down in Pittsburgh last year ruled that fluoride ingestion is mutagenic, can cause cancer, and is a menace to health. Fluoridation is linked with over 10,000 cancer deaths each year.
CASIMIR R. SHEFT D.D.S. President of New Jersey Citizens opposing Forced F.

Conclusion: Professor Harold P. Green of the George Washington University National Law Center points out: January, 1968

"Technological advances carry with them the very real threat of destruction of human beings and cherished human values.... How much damage could a single demented or evil person have inflicted on society in a single act 25 years ago? Today, such a person in a single act may have the capability of inflicting upon society immense damage measured in thousands, if not millions, of human lives."

FLUORIDATION DOES FAR MORE HARM THAN GOOD AND SHOULD BE ABANDONED AS A PROPOSED HEALTH MEASURE.
Our findings: There is no control over the daily intake of fluoride since no one can control the total water consumption of each person per day. There is much to be considered - climate, humidity, geographic conditions, engineering aspects, safety of the public, safety of the operator, qualifications, training, equipment involved.

The United States Dispensatory (24th Ed.) states that: Fluorides are violent poisons to all living tissues because of their precipitation of calcium. They cause fall of blood pressure, respiratory failure and general paralysis.

The Journal of the American Medical Association (February 10, 1951) reported: "Fluorine also tends to accumulate in the bones leading to hypercalcification (over-calcification and brittleness. Ligaments and tendons also become calcified.. Serious symptoms may ensue such as loss of mobility of joints, easy fracture and pressure on the spinal cord, decreased blood clotting power; and in women painful menstruation, lowered birth rate, high incidence of fracture, thyroid alteration and liver damage."

Archives of Environmental Health, AMA, May 1963," When inorganic fluorides are ingested in any concentration 50% is deposited in skeletal structures. In my considered judgement one of the implications of this insidious build-up of toxic fluoride in bone tissue could very well be the cause of bone cancer, leukemia, Hodgkins Disease and aplastic anemia-the bone marrow diseases. Blood cells are formed in bone marrow."

STATEMENT OF DR. LA SALLE D. LEFFALL, JR., PAST PRESIDENT, AMERICAN CANCER SOCIETY

Senator SCHMITT. The next representative—because apparently they have gotten together and put all their eggs into one basket—Dr. LaSalle D. Leffall, Jr., Past President, American Cancer Society.

Dr. LEFFALL. Mr. Chairman, I am Dr. LaSalle D. Leffall, Jr., professor, chairman of the department of surgery here at the Howard University College of Medicine here in Washington, and also a member of the National Cancer Advisory Board and past president of the American Cancer Society.

You will notice in our prepared statement that the American Cancer Society receives no funds from the Federal Government. Therefore, when we come to testify before this committee to ask for approval of the budget of the National Cancer Institute, we are doing it because we think of the National Cancer Institute as doing the job that deserves to be funded and funded at the level that they request.

Traditionally our citizen's budget has—for Government appropriations has increased this year. But this year, we are not asking for any increase in the budget at all; we are asking that this committee appropriate $1.135 billion to the NCI for the fiscal year 1982.

We oppose any rescissions for the fiscal 1981 budget.

I would like to state here that the American Cancer Society has full confidence in the National Cancer Institute and its leadership and Dr. Vincent DeVita, and its staff members. And we think that Dr. DeVita most appropriately established his position about the funding of the cancer program in an interview in the New England Journal of Medicine, and I would like to commend his remarks to you and respectfully request that those remarks be added to the record of this particular hearing.

Senator SCHMITT. Without objection, they will be.

[The information follows:]

Volume 303, Number 17

WASHINGTON REPORT

DANIEL S. GREENBERG

A Conversation with Vincent T. DeVita, Jr., M.D.

When the directorship of the National Cancer Institute became vacant early this year, the search committee pondered "insider" versus "outsider" — and decided on one of NCI's most veteran insiders: Vincent T. DeVita, Jr., M.D., who joined the Institute in 1963, two years after graduation from the George Washington University School of Medicine. In a career in which he distinguished himself in chemotherapy research and, in particular, for developing treatment for Hodgkin's disease, DeVita filled various posts at NCI. These include: Head of the Solid Tumor Service, Chief of the Medicine Branch, Director of the Division of Cancer Treatment, and, since 1975, Clinical Director, a position that he will continue to hold while serving as overall director of the Institute. President Carter formally appointed him to the directorship on July 9.

The following interview, from a conversation on August 6 at NCI, commences an occasional series of *Journal* interviews with persons who occupy influential positions in the biomedical community.

* * *

Q: Dr. DeVita, why is there frequent criticism that the cancer research system is unreceptive to unorthodoxy?

A: Because it's true. Not cancer research, all research systems. It's a very important issue, enough so not to shy away from talking about it. After all, the peer-review system is just people, and people always look a little bit suspiciously at the person who is way out at the edge. A very important part of my job is to be able to look at people in the middle and at the fringe and not be disaffected by somebody whose behavior seems to be a little bit strange or who seems to be coming from an unusual direction. The peer-review system tends to want to support investigators with proven records on proven tracks. We've supported a lot of people who have made important discoveries on the edge, too, but you have to be careful.

All of us who work in these kinds of jobs spend a lot of time talking to people who seem to be very "fringy." I spend a lot of time at it; I try to talk to everybody, because I'm concerned I might miss somebody who has a good idea. I have a Friday noon seminar I call my "connecting seminar," where I try to match science and administration; in other words, consider something that may require more money. To see if it's really as good an idea as the person says it is, I bring in a couple of people who know a lot about the field, plus the person who wants to make the presentation, plus the people who have their hands on the purse strings, and we sit and we talk. In a seminar format you get a feel for whether reactions are emotional and whether the science has some quality to it. How successful I've been, I haven't the foggiest notion.

The system, in fact, does tend to be somewhat conservative. I would change that immediately if I knew how to do it. But I don't know how to do it. It's the same as Churchill said about democracy: the worst possible system except for all others. I have never been able to come up with a satisfactory system that would infallibly reward the person who has the best ideas.

Q: What are some possibilities?

A: There have been several suggestions. The old patron system was just as supportive of losers, because there are a lot of people who are on the fringe who belong on the fringe, in the sense that they have crazy ideas, not sound ideas. The other is "play the winner," that is, if you've got somebody who has made important discoveries, then give him a career award. I am very interested in reexploring that. We have tried it here, and it always seems to run into trouble, I suspect, because you ultimately get down to the question of who is the winner. Is the winner the investigator who writes 100 papers every three years, or is the winner the scientist who has made a discovery that changed the direction of science? I don't think there is much question that if you can get the latter kind of person, you support him. That's the only way to do it. The entire system, if anything, tends to exclude people on the fringe who have ideas that are radical departures, and we ought to pay a lot more attention to them. We try. I try.

Q: Would broadening the disciplinary scope of the peer review panels be of help?

A: We do that, but the makeup of the study sections tends to be a little behind because of changing circumstances. We have to anticipate more than we are able to. Epidemiology in the cancer prevention area has in the last five years become extraordinarily important, and we've doubled our program in that area. So we now are in need of study sections that pay more attention to cancer epidemiology. And we are in fact changing them. If you do not appreciate that epidemiology is important, you are not going to change your study sections; so it's a matter of what comes first.

Q: What changes have occurred in regard to prevention?

A: Five or six years ago we reached a critical mass in our understanding of the causation of cancer, a shift from feeling that a virus was going to be the answer, to realizing that we might be able to manipulate most of the many things that cause cancer. That caused everybody to want to go in five different directions at once. The Institute was just not able to go that fast. The data suddenly became available for everybody to scrutinize. Everybody came to the same conclusion: more prevention research. Since we hold the money, if it's not being done, we are the ones not doing it. There is some truth to the criticism. We also have to deal with the bureaucracy, which is an incredible beast that has to be flogged every day.

Q: You can't personally dispose of any money, can you?

A: No. I can make adjustments in the system, though, and decide to overrule and fund a grant or a contract. I can't write a check for anybody. But there's no question that if you want to have somebody funded, you can force them into the system, and force people and the review system to listen to them; you can do it. And I would admit to you there are times I have done it. I made it a practice to do this when I was Director of Cancer Treatment. I haven't been NCI Director long enough to do that, but there are some people in the treatment area who have been discoverers — not just investigators but discoverers. You can go back and say, yes, this person discovered the following. I have one person in mind. The more this person discovers, because he is not known to be humble, the more people seem to want to go after him. I watch that person very carefully. When I see his grants, I track them around and find out who is selected for the site visits, and many times I find people have been selected who are known in advance to be avid critics of this particular person. That is one of the weaknesses of the peer-review system that I track. The fact is you have a lot of leeway. But that wasn't what I was referring to when I was talking about the beast itself. The beast is the procedures, the regulations, the personnel system that tends to slow you down so you can't get anything done. That beast is the one I was talking about beating. The beast seems to forget that we are here to prevent or cure cancer, not to perpetuate the Institute.

Q: What are the institutional interests that NCI must deal with today in the national cancer program?

A: As long as you don't do anything to institutional interests, they are usually relatively silent and don't make a big fuss about policy. You really find out who is doing what and why when you touch their programs, more than anything else. When you touch anyone, they usually say "ouch," and they say "ouch" in proportion to their organization and clout. Certainly, the cancer centers are very well organized and watch what we do — not only the comprehensive ones, but the specialized ones watch us very closely, and if we do something they don't like, they complain, and complain as a group, and have lots of people who will join them.

Q: Do academic researchers respond with the same sensitivity?

A: They are less well organized, and it's of some concern, because we fund more individual grants than any other kind of research. Not that I am crying for organized groups, but at times you need to have balanced input to balance priorities. And when you make a decision, as we have done — the NIH has as its top priority stabilizing the grants program — it costs you somewhere else, and when you make the adjustments to the funds, you usually hear from the people you adjust. But you don't hear necessarily from the individual grantees in the academic community about the pros and cons of what you did. You often get a lot of angry letters from the organized smaller groups and none from the larger groups made up of individual grantees.

Q: Doesn't the AAMC [Association of American Medical Colleges] speak for the academic researchers?

A: They do, but they are not that involved. They have never been, in my short time up here at least, that involved with the decision making on funding, perhaps because we always give priority to grants and they felt less of a need to do it. If you start out a year, and you announce, say, that only 25 per cent of our approved grants are going to be funded, you will get some response, but my quick impression is that we have never received a lot of organized response to that.

Q: Is it really so that academic researchers are generally so well cared for that they have no need to exercise lobbying muscle?

A: Relative to other kinds of programs, they get the proportionately larger share. There is no question about it. If you look at our budget, more goes into grants than goes into contracts or into anything else. They are getting the bigger share. But if you look at it by size of grant, you will find we are not giving enough to keep their research going. We are giving cost-of-living increases to some kinds of grants, cost-of-living increases that are unrealistic, 7 or 8 per cent, when the cost of research in laboratories is going up at 15 to 25 per cent. My impression from talking to people is that the grantees are doing less research than they could before on the amount of money we are giving them. But at least we are stabilizing the number of investigators in the pool. If they get a good priority score, they are getting money, but not enough to do the kinds of things they want to do.

Q: Does this then call for a new strategic approach as to how you use the available money?

A: We have to reset our priorities if the dollars don't come in, as they may not.

Q: What are your thoughts about resetting priorities?

A: We've done it already. When we were faced with a recision in 1980 and a reduced 1981 budget, we took one segment of our program we had under direct control at that time and went through it, one by one. It was our entire contract program, over 1500 contracts. We made reductions, and though the recision didn't pass, we didn't give the money back to those programs; we redistributed it to other programs. And in the future we are prepared to make the reductions we have to make; we have the money standing there ready to do it, if we need to. In addition, we have some programs we have talked about examining in toto to see if they still have a reason for existing.

Q: Like what?

A: One of the ones I've talked about, and it always gets me in trouble, is the organ site program that was set up in the early 70's because there were resources available and there wasn't staff here to do the kind of job we needed in certain kinds of common cancers; not much research was then going on in pancreatic cancer, bowel cancer, these kinds of tumors. These organ site programs have their own organization, they are run and staffed by outside people, and they have done a good job, I believe. Their total annual cost is about $17 million. But the situation is different now, eight years later. We have more staff, and the organ site programs have done what, in my view, is the most important job, which is to stimulate the field. If, in fact, the same people who now work in those areas came into the regular grant program, they would have to compete for the resources. Those organ site monies would then be diverted into the regular grant program. In very tight times, that seems to be something to be examined very closely. Once I was a member of what was called the lymphoma task force; it was the second task force ever formed by the Institute. It didn't last more than a couple of years, but it did what it was supposed to do, which was literally cause an explosion of work in the field, and then it went out of business. The breast cancer task force came into being at a time when there wasn't a lot of work going on in breast cancer, per se, and now everywhere you turn people are working on breast cancer. In my view, they have done an excellent job. Do you have to continue to have a task force that pockets the money instead of just putting it into the regular pool and letting all people compete for it?

Q: Are there any other of these compartmentalized funds that might be affected by a reordering of priorities?

A: Some of the programs we run by contract are subject to this kind of review. We've gone through the process and reduced some of these and redistributed funds. But there are things we do to make resources available to investigators out in the field, under contract. I am told by a lot of people that these resources are very valuable. But I am told by some that they were valuable but that technology has advanced to the point now that we are using very small amounts of the same reagents, different kinds of viruses, and, therefore, we could scale down production of these kinds of things. They are not huge sums of money, but they are sufficient to keep some of our programs going in hard times.

Q: What future do you see for the virus program?

A: As an independent program it's being blurred in a sense. We entered the 1970's still with the idea that there was going to be a virus discovered that could be identified as a cause of cancer and vaccines could be developed to help prevent cancer. That can't be absolutely ruled out. What's happened is that we've learned a lot about what viruses do in cells. They play a completely different role, it seems; they may be involved in regulating growth, interacting with other factors. The whole program thrust of trying to find that virus and getting a vaccine has just disappeared into molecular biology, or what is now called biological carcinogenesis. There was also a problem with that program. It did very good things — it still does — but it did it using a certain financial mechanism. And when the field scientifically began to change, the mechanism should have changed. The mechanism didn't change, and that's what caused a lot of concern. It was a contract-operated program. The much-abused contract has become so difficult to use now that it's become less useful to use it. Nonetheless, the contract is very useful sometimes. Many times the scientific community and the staff are on the same wavelength when something has to be done, and you use the contract to get something started. And then the program evolves and develops some momentum, a little bit like the organ site programs. And after it develops its own momentum, you can switch to the mechanism that favors spontaneity, and that's the grant mechanism. There was a time when the virus program itself should have made the transition from a targeted effort to a non-targeted effort, because the science was getting more basic rather than more applied. It wasn't going toward a vaccine; it was going into sequencing of genes and so on. And it didn't change. They kept managing it in the same way at a time when contracts, for a lot of reasons, some of which are true and some not, were constantly under attack. The virus program took it on the chin. There is a lot of very good science going on there mingled with some not-so-good science. So the decision, which I fully supported, to try to convert as much of this program as possible to grants is still in evolution; it's a good one. There are still some contracts that are being phased out slowly.

Q: Does this continuing loss of purchasing power suggest the need for seeking political support for more rapid growth for NCI?

A: I don't think so. I don't believe we need another special boost. The country is very well aware of the cancer problem. We are at a billion dollars roughly; that's a lot. There should be enough flexibility in a billion-dollar budget for us to be able to make whatever adjustments we have to make, for a period of time. Everybody has been affected by the fact that the economy is in difficulty, and however much congressmen may want to do for this or that program, they have to face a lot of people in this country who are concerned with feeding their families. Our friends, I believe, are still friendly, but like everybody else, they are trying to balance the budget. There is no question that some congressmen and senators are pro and interested in the cancer program, many for personal reasons, but they don't vote as much money anymore. I understand that. I have an interest in the cancer program. But I can't quarrel with the fact that there are other priorities making demands on the dollar. ■

CANCER SURVIVORS' INCOME TAXES

We have submitted data earlier that shows that the personal income taxes paid by cancer survivors will be putting more money into the Treasury than the National Cancer Institute has taken out for research investment.

And we support the National Cancer Institute, in addition to the imperative need to fight cancer, because we believe it is a cost-effective program, as I said before. We believe that the staff members, under the leadership of Dr. DeVita have shown us that they are on the right track and can give us some of the answers to cancer.

Mr. Chairman, there are two additional matters I will mention briefly.

The Health and Human Services Department's Office on Smoking and Health, and the Center for Disease Control State grants to fight the epidemic of new smoker addiction.

These items don't pertain directly to the National Cancer Institute, but I would like to mention them here and submit separate testimony, if you desire to consider those items at a different point in the hearing.

The Office of Smoking and Health has been investing about $2.5 million a year to maintain a national clearinghouse for information useful to the Government and to nongovernmental agencies trying to reduce the single most costly disease factor in the Nation.

This Office also prepares materials distributed by States and local governments and other groups.

It would be wasteful, we believe, for this centrally prepared material to be created in each State. The Office studies this massive health problem and then works with the Surgeon General to make the Government's decisive comment on it.

The President's budget would reduce the appropriation to $2 million in fiscal 1981 and $1 million in fiscal 1982.

This would ironically, maintain the staff, but not give them the contracting ability to do the computerizing of their information and to act on the facts that they have gathered. The staff would be in place with little ability to be effective.

Congress passed a measure 2 years ago which invests about $2 million a year to test and demonstrate ways of convincing schoolchildren not to take up the disease habits of smoking and alcoholism.

The first generation of demonstration projects is just about to be evaluated. The new block-grant system would probably destroy this effort to cut what is seen to be an epidemic of substance abuse beginning with children 9 to 11 years of age.

Fortunately, data seems to indicate that voluntary and Government efforts have slowed this epidemic and possibly have begun to reverse the trend. This money is urgently needed, and the $10 million should be appropriated to keep it up. I think an authorization renewal will be needed as well.

We will be back at this committee at a later date.

I have spoken very rapidly, Mr. Chairman, because I know there were some time constraints. But I just want to say in closing that the American Cancer Society supports very fully the budget of the National Cancer Institute, and further supports what is being done there under the leadership of Dr. DeVita and his staff.

Thank you very much.

Senator SCHMITT. Thank you, Doctor, we appreciate that very much.

[The statement follows:]

STATEMENT OF DR. LASALLE D. LEFFALL, JR.

Mr. Chairman I must preface this testimony with the fact that the American Cancer Society accepts no tax-derived funds for any of its programs. Therefore, what we ask for the National Cancer Institute appropriation in this testimony represents an objective citizens' view of the proper funding for the Institute and is in no way a direct or indirect appeal for money that will be used by the American Cancer Society.

Mr. Chairman, the American Cancer Society recommends that you appropriate $1,135 million to the National Cancer Institute in fiscal 1982.

This is the same amount that our Society recommended last year, to the dollar, with no addition for inflation.

There is today a popular mandate for restraint in federal spending and we, therefore, make this recommendation with the intent to support the current drive for federal fiscal restraint.

We are convinced that the money we recommend for NCI will be eminently well spent.

That conviction is based not merely on a patriotic devotion to the National Cancer Program. It is based on specifics.

First, the National Cancer Institute is in a transition period. The justifiably rapid growth it underwent after enactment of the Congressional priority stated in the National Cancer Act of 1971 was based on special research opportunities perceived at that time by scientists, science administrators, and practicing physicians.

There are those who would attack that 1971 decision, and I will discuss that in a few moments.

After the NCI's rapid growth, and after important improvements in therapy, a new director, Dr. Arthur Upton, was named to head the National Cancer Institute. He had special expertise in the science of chemical carcinogenesis. The Congress expressed special concern over chemical carcinogenesis. During Dr. Upton's term as director some important policy changes took place, partly because of his special talents and partly in response to Congressional concerns.

We now have a new NCI director, also a highly qualified science administrator and winner of research awards in his own right, and he has already reviewed many long-established programs and has searched for economies. He has begun a process of consolidation and transition which we think you will commend as you become familiar with it.

Probably the single most impressive part of this transition was NCI Director Vincent DeVita's early decision to review every single contract being funded by the National Cancer Institute. We have not consulted the archives, but we don't believe any NIH institute director ever made such a comprehensive survey of ongoing contract work in his institute. One result is that some $35 million in contract money is being saved outright and another $10 to $15 million has been transferred to projects of higher priority. The net effect is to make the cancer program leaner, more productive, finding within its own budget an opportunity for addressing part of the activity decline that must take place where inflation hits a no-increase budget. The NCI budget has been practically a no-increase budget in the last two years.

We recommend that you look carefully at the work plan and the funding of the National Toxicology Program and give NTP its own money, rather than use NCI as the pass-through agency.

At the same time, we recommend that the National Cancer Institute is engaged in activities very properly placed in NCI's work plan and that at least $35 million of the $45.6 million should be kept in NCI to perform the following functions:

1. Nomination of chemicals to be tested in bioassay testing. NTP should make the final selections, but the NCI's expert cancer advice should be considered.
2. Cancer-related research, including epidemiology, to provide an NCI view of what causes unusual concentrations of cancer in specific places in this country.
3. Continued research on development of test procedures, particularly in vitro (test tube) to reduce the use of extremely costly and time consuming animal screens.
4. Inter-species comparisons (rats with humans, as in the saccharin problem, for example); the study of causes and nature of human cell transformation, tumor promotion, anti-carcinogens, anti-promoters.
5. Maintain U.S. relations with the International Agency for Research against Cancer (W.H.O. unit at Lyons, France) where worldwide cancer research on this topic is monitored.

There is another aspect of transition which should be noted for the record, though you are aware of the general idea. The transition in recent years has involved winding down the cancer virus program and starting up the biological response modifiers program—interferon and related substances.

The cancer virus program started out to find a cancer vaccine, or vaccines. It has not done that. Such vaccines seem at present to be a remote hope if possible at all. The attempt to find a cancer vaccine has produced what is probably the most important flowering of new biology to come out of this century since the discovery of the double helix. The virus cancer program was not just a passing enthusiasm of virologists. It was a fact that, decades ago, a virus was identified as causing cancer in poultry and a successful anticancer poultry vaccine is used routinely now. A virus causing cancer in cows has been identified. A vaccine is possible there.

Despite the fact that no human cancer vaccine is in prospect the NCI virus cancer program has made major contributions to science. The Encyclopaedia Brittanica 1979 Yearbook said, "The achievement of successively deeper insights into the nature and function of deoxyribonucleic acids (DNA's) and the rise of a whole new field of science, molecular genetics, have been recognized by several Nobel Prizes . . . ."

Your Subcommittee, Mr. Chairman, and your predecessor Subcommittees, provided the funds through the National Cancer Institute virus program which went to men who have won Nobel Prizes for their molecular genetics work, including Daniel Nathans and Hamilton O. Smith.

It is in the finest tradition of government/private cooperation, a tradition which the American Cancer Society has been dedicated to since its foundation, that the National Cancer Institute research has helped inspire a growth industry, genetics engineering.

Here are a few notes from current business publications: Dece. 22, 1980, F-D-C Reports said Syntex is spending $66 million on research this year, much of it on recombinant DNA. The Bache, Halsey, Stuart, Shields firm's IMS Pharmaceutical Marketletter in May, 1980, predicted the 1989 world market for interferon would total $2.96 billion. In March, 1980, G.D. Searle & Co. announced plans to build a $12 million interferon plant. Some worldwide corporations are involved: Abbott Laboratories, Warner-Lambert, Merck & Co., Schering-Plough's subsidiary, Biogen, S.A., U.S. Vitamin, a division of Revlon Care Group; Abbott Laboratories, Toray Industries of Japan, Burroughts-Wellcome, Hoffman-LaRoche, Flow Laboratories in collaboration with Rentschler (West Germany).

Many people know, of course, that the American Cancer Society has allocated more contributors' money to interferon research than to any other research subject. The investment is close to $7 million. The timing was critical. We started very early. ACS-sponsored trials will soon provide conclusive benchmark patient outcome data so that each commercial variation, or genetics engineering manipulation, can be objectively measured for effectiveness. This ACS reference work is the critical start of the drug development process. It would be hard to cite a better case of basic research leading to successful applied research; of the private and government sectors working together with such good effect.

The Panel of Consultants to the Senate on the Conquest of Cancer likewise put a high priority on research into "markers," or human body fluids which tell of the presence of cancer. These markers, when refined, will be useful in screening populations for cancer and are already useful in screening selected populations having a high risk of cancer. Science magazine, the journal of the American Association for the Advancement of Science, reported (Feb. 27, 1981) that mass screening would not be economical with any one test now available, but that combinations of several tests might be practical, showing the trend clearly moving toward widespread use.

Again, the basic science work has been supported by the National Cancer Institute for over a decade and industry has in this case, too, invested heavily in new production lines. Companies involved include the Damon Corporation of Needham Heights, Mass.; and Sherwood subsidiary of Brunswick Corporation. Abbott Laboratories already has FDA permission to market tests for monitoring therapy in the U.S. and has been marketing the test in Japan and Europe. Other companies working on markers are Metpath, New England Nuclear, Mallinckrodt, and Nuclear Medical Systems.

In an entirely different area, Mead-Johnson has invested significant corporate research funds in clinical trials of ifosphamide for treatment of non-small cell carcinoma of the lung. Work at Georgetown University by Philip Schein, M.D., and at University of Texas-Galveston by John Costanzi, M.D., show ifosphamide, by itself, to show positive results, according to a Nov. 10, 1980, industry report. In other words, despite the cancer research community's sadness at lack of progress against lung cancer to match progress against the leukemias and lymphomas, here is a prominent corporation which thinks it wise to invest in a drug against lung cancer.

In 1968 and 1969 Dr. Sidney Farber in Boston showed two drugs could be effective against leukemia and other cancers. In 1961 NCI proved methotrexate could cure choriocarcinoma. In 1968 about two dozen drugs were useful against cancer. Drug development speed has about doubled. We now have more than 50 anticancer drugs. There is slowly growing, year by year, a significant advancement in saving patients. Still, too many of the obituaries in the daily newspapers cite cancer as the cause of death. The toll is terrible. The numbers are terrible and the pain is terrible. But more than three million people in the United States are alive today with a history of cancer. Of those, two million were diagnosed five or more years ago. On top of those millions alive today one could add another half-million persons alive and well every year despite diagnoses of certain skin and cervical cancers, because those are routinely cured and not even counted in cancer statistics any more.

That's real progress. Look at it a different way. Cancer is cured by surgery, radiotherapy, chemotherapy, and immunotherapy. After the traditional modes, surgery and radiotherapy, have arrested cancer, chemotherapy adds another 11,000 arrested cases per year. Against the hundreds of thousands of cancer patients that might not sound like much, but it is close to the number of deaths from polio in an epidemic year, and we all know the polio vaccine was one of the magnificent victories in man's centuries-long war against disease.

Is the War on Cancer worth while? In only a money sense, if we were to assume that every case of cancer arrested involves a person who pays income taxes, then apply the average personal income tax paid, we would produce a dollar value on cancer deaths averted of nearly $1.90 for every $1.00 invested in research. Of course it is true that many of the children saved don't pay income taxes yet. But they will. And that $1.90 figure only represents the value of the poulation with arrested cased for one year. They go on paying taxes year after year for the rest of their lives. We have already cited the figure of three million persons in the U.S. with arrested cases of cancer.

What would happen if we stopped cancer research? The cost of this disease would be enormous. Some of the costs would appear in the federal budget in the line item for Medicare or Medicaid. Some of it would appear in the line item for Veterans Administration hospitals. But most of it wouldn't appear in a line item at all. It might not appear in the federal government budget, but it surely appears in the national budget--that is, in the budgets of millions of families across the country.

The most recent expert study of this cost appeared in the American Journal of Public Health, December 1980 issue. In that article, a Harvard faculty member and two public health consultants, one with a master's in business administration, report a three-year study of theirs covered cancer, coronary heart disease, stroke, and motor vehicle injuries, each a leading cause of death. The total direct (treatment) costs of cancers was put at $6,411,000,000 in 1975. Indirect costs such as income lost or income foregone by reason of premature death totaled $16,737,000,000 for a total above $23 billion per year. This was 39% more than the cost of coronary heart disease, 60% more than motor vehicle injuries, and 258% more than strokes.

Give a thought to these figures. Motor vehicle injuries involve a good many young people, so indirect costs should be high, indeed. Heart disease is more prevalent than cancer. But like certain forms of cancer, it affects mostly older people, as do strokes. So the indirect costs--much of which is earnings cut off by premature death--are relatively low. Even when one takes account of cancer among old people, the overall costs of cancer turns out to be highest among these major killers. Cancer costs more than coronary heart disease and strokes combined.

That is why we in the American Cancer Society think that the federal government's investment of $1,135 million in National Cancer work in fiscal 1982 is a very worthwhile investment, indeed.

Certainly American industry thinks so. Certainly the three million persons in the United States with arrested cases of cancer think so.

STATEMENT OF GARETH M. GREEN, PROFESSOR AND CHAIRMAN, DEPARTMENT OF ENVIRONMENTAL HEALTH SCIENCES AT JOHNS HOPKINS UNIVERSITY

Senator SCHMITT. The next panel will have approximately four minutes each.

Dr. Gareth M. Green, Professor and Chairman, Department of Environmental Health Sciences at Johns Hopkins University; Janice Paradiso, Cooley's Anemia Foundation, Inc.; Dr. Ernst R. Jaffe, Head, Division of Hematology, Albert Einstein College of Medicine. Your prepared statements will be printed in their entirety after your oral presentation.

We will begin with Dr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

The American Lung Association and the American Thoracic Society, ALA's medical section, represent the citizens and the scientists of this country who are determined to prevent and control lung diseases. In addition to the identification which you gave me, I am also past president of the American Thoracic Society.

The problem we face is a major one that continues to grow, and now counts for an annual economic cost of $19.7 billion.

I would like to comment on my testimony that has been submitted for the consideration of the committee, rather than read it because of the shortness of time, emphasizing four points:

One is that respiratory disease is costly, it is increasing rapidly. In fact, it has grown faster than any other chronic disease category; over the past decade increasing 60 percent between 1968 and 1978. It is also disabling; one of every five persons reports some chronic respiratory problem. Chronic obstructive pulmonary disease is one of the most frequently named causes of disability under the Social Security Act. And, it accounts for over 50 percent of all acute illness in children. There are almost 5 million children who are afflicted with asthma and bronchitis.

The second point I wish to make is in the nature of support for research and manpower development to deal with the problems of pulmonary disease.

One of the problems that may not be entirely familiar to you is the fact that lung disease research and training, research and training that is important for pulmonary disease, goes on in several different Institutes at the National Institutes of Health and also in other agencies of the Government.

Therefore, our testimony makes recommendations regarding the budgets of the National Heart, Lung and Blood Institute; the National Institute of Allergy and Infectious Diseases; the National Institute of Environmental Health Sciences; and the National Institute of Occupational Safety and Health.

The research jurisdiction of NHLBI covers diseases that account for nearly one half of the deaths in the United States. The prevailing levels of research support have not kept pace with the opportunities for advancing our medical knowledge in the field of chronic respiratory disease. Only 28 percent of the qualified individual lung research grant applications can be funded at the present time, as compared to 45 percent as recently as 1979.

The National Institute of Allergy and Infectious Diseases is responsible for much of the new technology developed in the past decade, which is increasing our understanding of disease processes, and has stemmed from research traditionally supported by NIAID, virology, bacteriology, immunology, microbial genetics, and cell biology.

The National Institute of Environmental Health Sciences has a role which is increasingly important in the development of knowledge and understanding of environmental factors as they relate to diseases of the lung.

The National Institute for Occupational Safety and Health is an important aspect of the problems related to respiratory disease problems related to exposures of the workplace, including pulmonary diseases among miners.

I would also like to refer to problems of increasing occurrence of tuberculosis. In 1981 there was the first increase in tuberculosis since 1963.

Finally, I would like to make an especial appeal in regard to the problem of chronic obstructive pulmonary disease.

The American Lung Association and American Thoracic Society are convinced that the tools are at hand, after a decade of research, and the time is right to mount a sorely needed attack on the toll of chronic obstructive pulmonary disease, the most rapidly rising cause of death in the United States, and recommend that $15 million be specifically allocated for new initiatives against chronic obstructive pulmonary disease.

The American Lung Association, and the American Thoracic Society appreciate this opportunity to present funding recommendations related to disease of the lung, to the Congress in its consideration of appropriations for the Department of Health and Human Services.

We will be pleased to supply any additional information that would be helpful.

Thank you.

Senator SCHMITT. Thank you very much.

Next, Janice Paradiso.

Ms. PARADISO. I would like to let Dr. Jaffe speak first.

Senator Schmitt. All right. Go ahead, Dr. Jaffe.

STATEMENT OF DR. ERNST R. JAFFE, HEAD, DIVISION OF HEMATOLOGY, ALBERT EINSTEIN COLLEGE OF MEDICINE

Dr. JAFFE. Thank you. Chairman Schmitt and Senator Rudman, I am Ernst R. Jaffe, Professor of Medicine at the Albert Einstein College of Medicine in New York, and head of the division of hematology. And I am here speaking on behalf of the American Society of Hematology, which represents more than 3,000 practicing hematologists and biomedical investigators concerned with the problems of blood diseases.

Blood, which pervades throughout the entire body also pervades all of the Institutes of the National Institutes of Health. And therefore, the society for which I speak is concerned about continued and increased support for hematologic research programs supported primarily by the National Heart, Lung, and Blood Institute, the National Institute for Arthritis, Diabetes, and Digestive and Kidney Diseases, and the National Cancer Institute.

We would, therefore, Mr. Chairman, commend to you the written statement which we have submitted, and hope that you will have an opportunity to read it, and I will just summarize very briefly that our recommendation for the National Heart, Lung and Blood Institute is for an appropriation of $625 million in fiscal 1982; for the NIADDKD, which used to be the NIAMDD, $410 million; and $1.06 billion for the National Cancer Institute.

In addition, we would recommend disapproval of the rescissions of the NIH funds in fiscal 1981 continuing resolution, because many of the Institutes are now holding back funds, being unable to fund the approved grants with high priorities. And we are concerned that turning off research programs and trying to start them up again after personnel has been discharged or reassigned, will be much more costly than if we just maintain the programs that have passed muster in the peer review system.

Finally, I would like to recommend that we maintain research training support at the recommended level of about 10,500 trainees a year, because again turning on and turning off, whipsawing the young physicians and biomedical scientists—one year they are told they are going to get training support, the next year they are not—is not very conducive. It has been extremely demoralizing.

Certainly, we are going to need these trained biomedical scientists to continue to do the research that we are prepared to do, if you gentlemen will continue to provide us with the support that we need.

Thank you very much.

Senator SCHMITT. Janice Paradiso.

STATEMENT OF JANICE PARADISO, COOLEY'S ANEMIA FOUNDATION, INC.

Ms. PARADISO. Mr. Chairman, thank you for permitting us to testify today on behalf of appropriations for research and care in Cooley's anemia.

Cooley's anemia is the name commonly used to describe the severe form of hereditary disease of the blood. This disorder occurs most commonly in individuals whose ancestors were natives of the country surrounding the Mediterrean Sea. In the United States, patients are of Italian, Greek, Turkish, southern France, northern African, Chinese, Spanish, Irish, and Israeli descent.

Information describing this disease at length is attached to our testimony. In short, the foundation urges the Labor-HHS Appropriations Subcommittee to consider the following recommendations:

Funding levels for the so-called reserve B. & M. R. funds of the maternal and child health program be sufficient to fund Cooley's anemia programs now under consideration as a result of congressional appropriations bill report language of last year.

Second, we urge you to carefully consider that the impact of a block grant program on the above-noted Cooley's anemia program to insure that such block grants will not interfere with timely action on them, that the Heart, Lung and Blood Institute be funded at $625 million for fiscal year 1982 and that the proposed rescissions for fiscal year 1981 for that Institute not be agreed to and lastly, let the National Institute of Arthritis, Metabolism and Digestive Diseases be funded at a level of

$409 million for fiscal year 1982 and that the proposed rescissions for fiscal year 1981 for that Institute not be agreed to.

Thank you very much.

Senator SCHMITT. Thank you. If I may use the chairman's prerogative to ask the question: Why are the Chinese and the Irish on your list? What are the anthropological, demographics of that?

Ms. PARADISO. Well, through intermarriage, you know, when populations mingle and change.

Senator SCHMITT. Did it have to do with comingling in this country?

Ms. PARADISO. Yes.

Senator SCHMITT. And, doctors, again—do you really think that smoking and health program in the Federal Government is having any positive effect? I'm as much antismoking as anybody in the world, but we really need to know whether that kind of an effort is having an effect.

Dr. GREEN. I would think the removal of a program directed against smoking and health is a serious detraction from the concerns, the magnitude of the problem of smoking and health in this country.

Senator SCHMITT. I understand that. I'm sympathetic with it, but isn't the real effect of this program no more than just making us feel good because we're trying to do something? Is it effective at all?

Dr. GREEN. I think the information and the literature that has been developed and distributed has been extremely influential in bringing attention to the problems of smoking and health.

Dr. JAFFE. Mr. Chairman, if I might comment, and I'm no expert on this, but it's been my impression there has been an impact. I don't believe the young people are smoking cigarettes, that is tobacco cigarettes, quite as much as they used to.

Senator SCHMITT. But it's hard to say at this point whether it's a cause and effect.

Dr. JAFFE. Exactly.

Senator SCHMITT. OK. Well, I'm looking for ways to solve that problem, and I haven't yet been convinced that this is one of them. Thank you. I appreciate it.

The next witness for the National Institute of Dental Research, Dr. Benjamin F. Hammond, Member and Past President of the American Association for Dental Research.

[The statements follow:]

STATEMENT OF RICHARD SINSHEIMER, PRESIDENT, AMERICAN LUNG ASSOCIATION

The American Lung Association and the American Thoracic Society, ALA's Medical section, represent the citizens and the scientists of this country who are determined to prevent and control lung diseases. The problem we face is a major one that continues to grow and now accounts for an annual economic cost of $19.7 billion.

Chronic obstructive pulmonary disease (COPD) underwent the most rapid rate of increase (60%) among the leading causes of death in the United States between 1968 and 1978. COPD has jumped to fifth place among causes of death due to disease, while pneumonia and influenza remain the fourth most common disease cause of death. About one in every five persons report some chronic respiratory problem and COPD is one of the most frequent diagnostic categories awarded disability under the Social Security program. Respiratory illnesses account for over 50 per cent of all acute illnesses in children. Asthma, bronchitis and bronchiolitis are the causes of nearly 5 million respiratory cases in the childhood population.

Incredible as it may seem, there were some 28,000 new cases of tuberculosis last year. According to provisional data, this represents an 0.6 per cent increase, the first year since 1963 that the nation has experienced an increase in new TB cases. Up to last year, there has been a yearly decrease of between five to six per cent.

On still another front, occupational lung diseases have multiplied at a rapid rate as societal problems involving industry, the courts and the government.

Clearly, lung disease must be dealt with as a priority need. We urge that public policies call for increased efforts by federal programs that can make a significant difference in our lung health future.

The American Lung Association and the American Thoracic Society have evaluated the proposed 1982 budgets for the National Heart, Lung and Blood Institute and its Division of Lung Diseases, as well as the other Institutes and agencies responsible for lung research, training, prevention and education. Frankly, we are deeply concerned that unrealistically low budgets that have been proposed will cost much more in the long run than the supposed short-term savings. Our concern is for sorely missed research opportunities and dismantled programs which will cause lost momentum in key areas.

National Heart, Lung and Blood Institute

We recommend a fiscal 1982 appropriation of $625 million for the National Heart, Lung and Blood Institute. This will permit the continuation of existing NHLBI programs with modest increases related to the cost of living. Proportionately, this Institute's appropriations is low when compared to its research responsibility for diseases which cause nearly half of all our deaths.

Basic research on the structure and function of the lung and on the development of diseases of the airways and lung parenchyma continues to disclose the ways in which dust particles and toxic vapors associated with job, home and air pollution cause chemical injury to the lung. This understanding offers new opportunities for treatment and prevention of pulmonary diseases and control of the costly and debilitating effects of chronic bronchitis, asthma, emphysema, pulmonary fibrosis and pulmonary vascular diseases.

Of major significance for the coming fiscal year is the renewal of the Specialized Centers of Research (SCOR) programs in lung diseases, a program that integrates basic, clinical, and epidemiologic field research at 20 university institutions across the country into a nationwide network of research and development in pulmonary disease. Resources are available to support only a minority of the available research proposals submitted in this competition.

The proportion of qualified individual lung research grant proposals that can be funded from diminishing resources continues to fall at an alarming rate -- from 45% in 1979 to 28% in 1980 and 1981. Institute contracts in pulmonary disease which support collaborative clinical trials and technological developments have fallen to an all-time low of only 5% of the budget alloted for lung research and development.

The lung community is convinced that the time has come to hold the line against decreasing resources available to fight the most rapidly rising cause of death in the United States -- chronic obstructive pulmonary disease. See Attachment A.

Over the short space of a decade since the founding of the national lung program, the NHLBI has developed a scientifically advanced, administratively sophisticated, and fiscally efficient research, education, and prevention program against chronic obstructive pulmonary disease. Tools are now at hand to commence a well-planned and integrated evaluative program of research, clinical management and education to achieve prevention and control of the disease over the next decade and halt the rapid rise in illness and death from this disorder.

The American Lung Association and the American Thoracic Society urge the appropriation of a sum of $15 million over and above funds allocated for existing research programs after increments for the cost of living. This additional $15 million would be specifically earmarked for initiation of badly needed new programs against chronic obstructive pulmonary disease. The Institute budget is simply too tight to mobilize needed funds for these new initiatives:

> Basic research on respiratory muscle fatigue that leads to respiratory failure, and new technology for monitoring chemical changes in tissues that signal these changes ($2 million); clinical research on immunologic methods for early detection, development and testing of synthetic protease inhibitors and inhibitor replacement therapy for treatment ($3 million); several longitudinal epidemiologic studies to define and detect risk factors, to correlate and compare acute and long-term effects of smoking in males vs. females, and to determine the effectiveness of treatment of mild respiratory dysfunction detected in population surveys ($5 million); and prevention and education projects to evaluate the strategies of health education that encourage compliance with medical treatment and advice, to assess and enhance the use of spirometry to detect and manage chronic obstructive pulmonary disease in large populations, and to study pulmonary rehabilitation in community hospitals ($5 million).

The opportunity, in terms of state-of-the-art, is at hand to make a quantum jump in the effort to control the escalating fiscal and human burden of chronic obstructive pulmonary disease. The American Lung Association and the American Thoracic Society respectfully urge favorable actions on these recommendations.

National Institute of Allergy and Infectious Diseases

We propose that $260 million be appropriated for the National Institute of Allergy and Infectious Diseases. The research responsibilities of NIAID include a number of respiratory disorders, such as tuberculosis, asthma, the influenzas and pneumonias and a host of other bacterial, viral and immunologic diseases that affect the lung. It was NIAID whose support led to an effective vaccine against pneumococcal pneumonia. As you well know, Congress recently approved the vaccine's use in the Medicare program, an action endorsed by ALA and ATS.

Much of the new technology developed in the past decade which will do much to increase our understanding of the disease process has stemmed from biomedical sciences traditionally supported by NIAID: virology, bacteriology. immunology, microbial genetics and cell biology. This scientific evolution will continue to have a profound impact on both research and clinical practice in terms of prevention, diagnosis and treatment of infectious and immunologically-mediated diseases.

This Institute's research with viruses has great potential for expanding our knowledge about degenerative chronic disease. Immunologically-mediated diseases are very significant areas of new research in respiratory disease. NIAID's work in asthma is of great importance because this condition affects more than 6 million persons, many of them children and young adults. Much of NIAID's research relates to the efforts of other NIH institutes and the leaders of NIAID and NHLBI as well as NCI are to be commended for taking advantage of collaborative opportunities.

NIAID-supported studies have identified opportunities for increased research in human biology. These studies covered bronchial asthma, problems of allergic children, drug allergy, occupational asthma and related immune disorders, epidemiology of acute viral infections, chronic diseases possibly associated with persisting viral infections and new and improved live and inactivated virus vaccines.

National Institute of Environmental Health Sciences

It is our recommendation that the 1982 appropriation for the National Institute of Environmental Health Sciences be $112 million. A significant portion of the work of this Institute relates to pulmonary health. Among its important and timely work is research in the pathology of lung disease related to the effects of the processing of coal and to materials used in energy conservation. Other important studies are being conducted in environmental carcinogenesis and the lung, directed at trying to determine the crucial interactions between host and environmental factors. NIEHS has been given the lead role in the National Toxicology Program and is working closely with the National Institute for Occupational Safety and Health to set up a practical system to identify and evaluate multitudinous chemical hazards.

The NIEHS training and manpower development programs have grown considerably in the past four years in response to the national manpower need stimulated by the passage of the Toxic Substances Control Act of 1976. NIEHS is not only responsible for training competent academic investigators but is training scientists who can work for other government agencies, testing laboratories and industrial firms in the fields of environmental toxicology, comparative pathology and epidemiology.

National Institute for Occupational Safety and Health

We recommend [illegible]hat the 1982 appropriation for the National Institute for Occupational [illegible]alth be $90 million. This Institute has a primary role in national efforts to protect the work force from hazards through the development of standards. Much of the Institute's work at the Appalachian Laboratory is devoted to respiratory disease and how it develops as a result of occupational exposure. A vital part of NIOSH is its Educational Resource Center program which is responsible for a key portion of manpower development in prevention and control of respiratory and other diseases at the workplace.

NIOSH is planning to solicit research grants in the area of adverse health effects from mining, including the documentation of the prevalence of pulmonary disease among miners exposed to varying levels of particulates and other pollutants in mining operations and also grants relating to the association between respiratory diseases and exposure to fibrous minerals and metals in mine atmospheres. It is expected this solicitation will increase the number of research grants applications in the area of miners' health approximately three-fold. NIOSH also believes that there is an urgent need to study the health effects of works exposed to clay minerals, including kaolin. These widely used ceramics materials produced some case reports of respiratory disease among workers.

Tuberculosis and 314(d)

It is recommended that $68 million be made available in appropriations for Sec. 314(d) in 1982, assuming that this program will retain its separate identity that year. If, on the other hand, the proposal of the Administration for a block grant is adopted and signed into law, we recommend that the Sec. 314(d) level for consolidation be computed at the rate of $68 million. The authorization for appropriations for 1981 was $170 million.

The prevention and control of tuberculosis continues to have a high priority of the American Lung Association and the American Thoracic Society. Tuberculosis, like other infectious diseases, is no respecter of State boundaries and is a national problem. The provisional figures of the Centers for Disease Control for 1980 show an increase in reported cases over the preceding year for the first time in many years. The only source of Federal support for the control of tuberculosis at this time is Sec. 314(d) of the Public Health Service Act which authorizes Federal formula grants for comprehensive public health services. Virtually all States chose to use a portion of these funds for tuberculosis control because of its threat to health.

Information concerning the level of funding for tuberculosis by States, including Sec. 314(d) funding, and statistical data concerning the distribution of newly reported cases of tuberculosis by States and cities is attached to this statement. See Attachments B, C, and D.

Smoking and Health

It is our recommendation that the 1982 appropriations for the Office of Smoking and Health which is in the Office of the Assistant Secretary for Health in the Department of HHS be funded at the level of $3 million and that the alcohol abuse and smoking education grants administered by CDC be continued at their present level of $10 million.

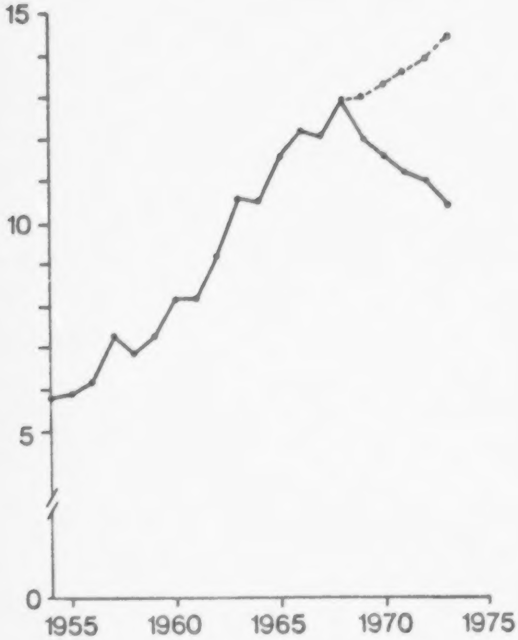
Cigarette smoking is estimated to cause approximately 350,000 premature deaths each year in the United States. It also takes a heavy toll in terms of illness and disability, and is a significant factor in Medicaid, disability and welfare costs. The modest budget of this program has paid for itself many times over and has been a valuable resource to organizations such as ours.

Pediatric Pulmonary Centers

It is our recommendation that the program for Pediatric Pulmonary Centers which receive funding from the Research and Training budget of the office of Maternal and Child Health be continued at its current level in the 1982 budget. MCH Research and Training is now funded at $30 million and the Centers are allocated $3.5 million.

The PPC's function as referral centers for the expert diagnosis and treatment of pediatric pulmonary problems. Many of the children admitted have asthma or cystic fibrosis -- some are infants with life-threatening respiratory problems. The centers also provide training opportunities in pulmonary disease for medical and paramedical personnel.

Attachment A



Age-adjusted Death Rates for
Bronchitis, Emphysema, and Asthma,
United States, 1954-1973,
(Deaths per 100,000 Population)

Figure 1

The solid line indicates age-adjusted death rates for bronchitis, emphysema, and asthma from 1954 through 1973. The dashed line indicates these rates plus age-adjusted death rates for "chronic obstructive pulmonary disease," which has been reported as a cause of death with increasing frequency since 1969.

Source: Based on data derived by Dr. G. Comstock from 1954-1969 Vital and Health Statistics and 1970-1973 Vital Statistics of the United States.

In 1970, there were 1.54 million newly diagnosed cases of chronic obstructive lung diseases (4). The overall prevalence of chronic bronchitis or emphysema associated with a disabling degree of airways obstruction cannot be estimated with precision, but these disorders probably affect several millions of Americans. Thus, by any criteria, they represent major public health problems in the United States.

Attachment 8

Actual Expenditures in 1980 and total Funds Required in 1981, by State, for the Prevention and Control of Tuberculosis

State	Thousands of Dollars Actual Expenditures 1980 Total	Sec. 314 (d)	Estimated 1981 Need
Alabama	2,471	35	2,937
Alaska	1,020	40	1,100
Arizona	1,176	80	1,700
Arkansas	1,059	41	1,309
California	1,600	700	400
Colorado	508	152	572
Connecticut	1,056	28	900
Delaware	155	-	171
Florida	2,133	365	2,564
Georgia	888	177	1,151
Hawaii	937	142	1,134
Idaho	240	-	150
Illinois	103	36	305
Indiana	248	216	285
Iowa	51	-	55
Kansas	313	142	332
Kentucky	2,732	32	3,000
Louisiana	1,511	460	1,830
Maine	256	65	256
Massachusetts	2,825	80	3,350
Michigan	750	-	2,000
Minnesota	35	-	110
Mississippi	1,466	25	2,500
Montana	18	3	30
Nebraska	246	-	270
Nevada	234	-	381
New Hampshire	125	28	140
New Jersey	2,173	498	2,000
New Mexico	360	78	400
New York	3,500	240	5,000
North Carolina	7,700	8	10,000
North Dakota	113	52	61
Ohio	600	55	600
Oklahoma	463	263	525
Oregon	265	200	250
Pennsylvania	3,771	3,071	4,500
Rhode Island	210	40	350
South Carolina	621	330	1,139
South Dakota	169	133	250
Tennessee	4,686	34	4,400
Texas	6,993	-	7,225
Utah	116	-	160
Vermont	154	10	164
Virginia	975	-	1,100
Washington, D. C.	587	67	1,000
Wisconsin	206	34	336
Wyoming	27	27	32
West Virginia	500	-	531
Puerto Rico	1,000	600	1,100
Total	59,345	8,587	70,055

Source: State Health Department reports to the American Lung Association. Excluded are funds independently appropriated and expended by local governments. 2-26-81

Attachment C

TABLE 5
Tuberculosis Cases by Racial Designation, States, 1979

State	Total Cases	White	Black	American Indian	Asian American	Other	Not Stated
United States	27,669	14,021	6,698	463	1,698	592	4,197
Alabama	644	308	322	8	1	5	0
Alaska	90	12	0	0	2	76	0
Arizona	417	268	25	112	12	0	0
Arkansas	382	246	132	1	0	3	0
California	3,642	2,339	404	42	770	66	22
Colorado	170	100	13	7	45	5	0
Connecticut	169	96	45	0	9	19	0
Delaware	63	30	32	0	0	1	0
District of Columbia	324	19	284	0	13	0	8
Florida	1,628	917	687	2	11	9	2
Georgia	929	362	–	–	–	–	567
Hawaii	311	12	0	0	292	0	7
Idaho	21	19	0	2	0	0	0
Illinois	1,540	738	581	12	69	137	3
Indiana	509	376	–	–	–	–	133
Iowa	74	64	5	1	7	7	0
Kansas	104	78	13	0	7	6	0
Kentucky	635	556	76	1	1	2	0
Louisiana	647	279	330	0	7	24	7
Maine	56	54	0	0	2	0	0
Maryland	648	307	288	0	12	41	0
Massachusetts	476	336	80	0	28	32	0
Michigan	1,052	515	476	8	35	18	0
Minnesota	190	112	9	8	46	13	2
Mississippi	553	228	315	5	5	0	0
Missouri	500	370	101	6	10	10	3
Montana	39	18	0	20	1	0	0
Nebraska	30	23	4	0	1	2	0
Nevada	54	35	3	8	8	0	0
New Hampshire	25	23	0	0	1	1	0
New Jersey*	933	–	–	–	–	–	933
New Mexico	153	82	2	59	0	10	0
New York*	2,229	–	–	–	–	–	2,229
North Carolina	990	359	599	7	0	25	0
North Dakota	22	18	0	3	0	1	0
Ohio	764	487	–	–	–	–	277
Oklahoma	352	234	61	62	2	10	3
Oregon	179	134	12	8	25	0	0
Pennsylvania	1,076	667	339	1	23	46	0
Rhode Island	80	59	9	3	6	2	1
South Carolina	483	123	354	0	6	0	0
South Dakota	65	16	0	39	1	0	0
Tennessee	748	539	200	0	1	8	0
Texas	2,090	1,544	456	5	85	0	0
Utah	46	35	2	2	5	2	0
Vermont	29	29	0	0	0	0	0
Virginia	747	327	372	0	37	11	0
Washington	321	185	16	26	95	0	0
West Virginia	221	185	29	3	4	0	0
Wisconsin	210	163	22	12	13	0	0
Wyoming	19	18	0	1	0	0	0
American Samoa**	2	0	0	0	0	2	0
Guam**	62	0	0	0	0	62	0
Puerto Rico**	464	–	–	–	–	–	464
Trust Terr. Pacific Is.**	31	0	0	0	0	31	0
U.S. Virgin Is.**	8	2	6	0	1	0	0

* Cases reported by the States of New Jersey and New York were not identified by race. New York City did report the racial designation of cases and these are shown in Table 15.

** Not included in totals. Puerto Rico cases were not identified by race.

(..) Not available.

Attachment D

SELECTED DATA CONCERNING TUBERCULOSIS
IN CITIES OF OVER 250,000 POPULATION

	No. of Cases 1979	Case rate per 100,000		1979			
				Number of cases			Number under 5 years
		1979	1978	White	Black	Other	
Austin, Texas	39	11.6	12.3	27	8	4	2
Baltimore, Maryland	293	37.5	48.3	89	192	12	8
Birmingham, Alabama	79	27.6	38.1	15	62	2	3
Boston, Massachusetts	140	22.6	27.5	52	60	28	2
Buffalo, New York	62	16.6	16.0	*	*	*	0
Chicago, Illinois	869	25.8	29.6	254	484	128	16
Cincinnati, Ohio	82	20.7	19.4	37	*	*	4
Cleveland, Ohio	124	20.3	25.8	52	*	*	7
Columbus, Ohio	63	11.7	11.1	36	*	*	2
Dallas, Texas	168	17.4	20.8	102	54	12	9
Denver, Colorado	74	16.0	14.4	38	6	30	8
Detroit, Michigan	456	35.4	43.7	109	340	7	19
El Paso, Texas	75	18.3	20.7	71	1	3	4
Fort Worth, Texas	124	27.9	16.8	74	46	4	5
Honolulu, Hawaii	178	49.1	44.6	7	0	166	4
Houston, Texas	474	29.2	25.4	279	161	34	15
Jacksonville, Florida	81	14.2	23.3	31	48	2	0
Kansas City, Missouri	51	11.1	16.8	26	21	4	0
Long Beach, California	60	17.2	17.7	35	8	17	3
Los Angeles, California	685	24.4	26.2	449	142	87	36
Milwaukee, Wisconsin	93	15.2	16.8	61	28	4	2
Minneapolis, Minnesota	42	11.3	14.4	21	3	16	2
Newark, New Jersey	161	51.5	39.6	*	*	*	15
New Orleans, Louisiana	201	35.3	33.3	80	106	13	19
New York, New York	1,530	20.1	17.2	702	701	127	32
Norfolk, Virginia	62	22.2	23.1	14	46	2	2
Oakland, California	75	22.7	20.4	23	34	17	2
Oklahoma City, Oklahoma	75	19.7	13.1	46	20	9	4
Philadelphia, Pennsylvania	356	20.2	23.1	114	212	30	10
Phoenix, Arizona	125	16.5	14.8	97	10	18	5
Pittsburgh, Pennsylvania	73	16.9	20.8	29	40	4	3
Portland, Oregon	80	21.6	22.4	54	10	16	7
Rochester, New York	41	16.3	14.5	*	*	*	2
St. Louis, Missouri	76	15.2	16.3	36	38	2	0
St. Paul, Minnesota	44	16.3	9.3	12	4	28	2

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* Not available.

Attachment D

SELECTED DATA CONCERNING TUBERCULOSIS
IN CITIES OF OVER 250,000 POPULATION

	No. of Cases 1979	Case rate per 100,000		1979			
				Number of cases			Number under 5 years
		1979	1978	White	Black	Other	
San Antonio, Texas	142	18.2	16.3	124	13	5	7
San Diego, California	148	17.9	19.2	84	11	53	6
San Francisco, California	358	54.5	50.4	76	55	227	11
Seattle, Washington	109	22.7	16.1	38	11	60	2
Tampa, Florida	83	30.0	28.5	50	33	0	1
Toledo, Ohio	37	10.2	10.7	19	*	*	0
Tuscon, Arizona	44	13.5	17.9	37	4	3	0
Tulsa, Oklahoma	41	11.3	8.4	28	12	1	0
Washington, D. C.	324	49.4	46.6	19	284	13	10
Wichita, Kansas	23	8.8	8.4	16	3	4	0
Total -45 Cities	8,520	23.1	23.5	3,562	3,311	1,192	291
COUNTIES **							
Albuquerque-Bernalillo, N.M.	33	8.6	7.4	23	2	8	1
Atlanta -Fulton, Ga.	198	32.2	37.2	46	*	*	11
Charlotte-Mecklenburg, N.C.	63	15.9	15.9	16	47	0	0
Indianapolis-Marion, Ind.	148	18.7	17.2	83	62	3	1
Louisville-Jefferson, Ky.	82	12.1	17.0	59	22	1	1
Memphis-Shelby, Tenn.	109	14.4	18.5	28	81	0	3
Miami-Dade, Fla.	333	21.9	20.0	168	159	6	12
Nashville-Davidson, Tenn.	68	15.0	18.9	37	30	1	0
Omaha-Douglas, Nebr.	14	3.4	2.4	10	4	0	0
Sacramento-Sacramento, Cal.	112	14.8	14.9	41	11	60	0
San Jose-Santa Clara, Cal.	140	11.2	11.8	76	4	60	7
Total -11 Counties	1,300	16.2	17.0	587	422	139	36

* Not available.
** Counties which include a principal city of 250,000 population or more.

Source:1979 Tuberculosis Statistics : States and Cities
U. S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, Georgia
July 1980 Issue

STATEMENT OF DR. ERNST R. JAFFÉ

Thank you for allowing me to present testimony before this Subcommittee on behalf of the American Society of Hematology in connection with the Fiscal 1981 and Fiscal 1982 appropriations for the National Institutes of Health.

I am Dr. Ernst R. Jaffé. I am the Head of the Division of Hematology in the Department of Medicine, as well as Professor of Medicine, at the Albert Einstein College of Medicine, Bronx, New York. I am also the Chairman of the Public Information Committee of the American Society of Hematology. This Society is the only national organization of hematologists. It is comprised of physicians and biomedical scientists who are concerned with research, patient care, and teaching activities as they relate to blood. Blood, the liquid of life, is all-pervasive, for it perfuses all organs and tissues of the body, bringing essential oxygen and nutrients to the sites where needed, and carrying away carbon dioxide and the waste products of the body's metabolic activity.

Because blood is everywhere in the body and aberrations in its quality or quantity can influence profoundly the functions of the organs and tissues, it is not surprising that some funds from every single Institute in the NIH, and the Division of Research Resources, have been devoted to extramural blood and blood-related research. Although this hearing is devoted to the National Heart, Lung, and Blood Institute, and the NHLBI provides the largest share of funds for blood research, I must note that the National Cancer Institute and the National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases also have major commitments to the advancement of biomedical science in this area. Eighty percent of all blood-related research has been supported by these three Institutes. The physicians who are members of the American Society of Hematology, therefore, are vitally concerned about the continued viability of their programs. Investments made now in the development of basic information about the causes of disorders of the blood, even in an era of fiscal austerity, can and will pay handsome dividends in the future in the prevention of disease, avoidance of lost productivity, and reduction in the cost of health care delivery. You have heard or read about what biomedical research has accomplished in the past, and I will not dwell on these achievements here. I would, however, like to highlight some of the potential breakthroughs that are awaiting funding and that may very well have beneficial consequences as dramatic as the discovery of penicillin, the development of a vaccine for poliomyeltis, or the identification of means to avoid the consequences of hereditary disorders such as phenylketonuria.

Thousands of patients each year are afflicted by the results of blood clotting in the wrong place and at the wrong time: heart attacks, strokes, and emboli (blood clots) that travel in blood vessels to obstruct vital arteries. Heparin is one of the most widely used medicines for the treatment of patients with thromboembolic disorders. There is, however, a wide variability in the effectiveness of different preparations. Attempts have been made for many years to define the structural similarities between highly effective heparin preparations in order to try to avoid the problems associated with the need to administer massive doses that are at times required to maintain a reasonable, effective level of anticoagulant activity. A unique sugar sequence has recently been identified whose presence seems to correlate with biologic potency, suggesting that this structure may represent the critical site responsible for heparin's "blood thinning" effect. Obviously, further efforts to confirm and extend these observations, and to permit the development of pure, uniformly effective heparin would be of inestimable value to patients requiring its administration.

In striking contrast to the patients affected by the formation of blood clots are those who suffer from excessive bleeding, especially hemophilia. While we know that a specific protein, Factor VIII, that can be collected from normal blood can control the debilitating and sometimes fatal bleeding in these men and boys, there are some unfortunate hemophiliacs who develop inhibitors that counteract the beneficial effect of Factor VIII preparations. A special concoction, prothrombin complex concentrate (PCC), may be able to overcome this inhibition, but proper evaluation of this material will require carefully controlled, randomized clinical trials to make sure that the favorable effects so far reported are not just the result of the so-called placebo effect associated with the introduction of any new therapeutic modality for a disorder that worsens and improves intermittently. An activated form of PCC may be even more effective than the inactivated concentrate, but the former costs $1.30 per unit, while the latter is only about $0.12 per unit. The need for further support of such studies can hardly be questioned when the potential benefits are considered in terms of the reduction of hospital or clinic care and the loss of productive work time.

Much has been written and broadcast about the possibility of treating patients with aplastic anemia, those whose bone marrows have stopped manufacturing red blood cells to carry oxygen, white blood cells to fight infection, and platelets to control bleeding, by transplanting bone marrow from unaffected twins, blood relatives, or unrelated donors. Only a few patients with this dread disease are fortunate enough to have identical twins from whom bone marrow may be obtained and transplanted with relative ease. While some success has been achieved in transplanting marrow from unrelated donors, further efforts to identify the factors that will determine success or failure are obviously indicated. Not infrequently, patients with aplastic anemia have had to be transfused with blood before transplantation. These life-sustaining transfusions, however, may also sensitize the patients against the future donor's marrow, resulting in rejection and failure of the transplant. Identification of tests that can be done simply, easily, and quickly in the test-tube to provide forecasts of those patients who would be most likely to reject a bone marrow graft would, obviously, avoid unwarranted attempts and would save countless millions of dollars. One never likes to give up on a patient, but a compassionate physician also wishes to protect a patient from any hazardous procedure doomed to failure.

Hereditary disorders of the red blood cells, in particular thalassemia major (Cooley's anemia) and sickle cell disease, have taken their toll of mankind over the centuries. Understanding of the basic defects in the formation of the oxygen-carrying pigment, hemoglobin, in these patients' red blood cells has begun to permit the design and examination of potentially useful therapeutic maneuvers. In Cooley's anemia, a major problem is the accumulation of unwanted iron in such organs as the heart, pancreas, and liver secondary to the many transfusions that those afflicted require to grow to adulthood and maintain some semblance of a normal life. Transfusion with normal, young red blood cells has reduced to a modest degree the frequency of transfusions and, thereby, the intake of iron. Removal of the excess iron by administration of medicines that bind iron for excretion has also been achieved but further studies are needed to identify the best chemicals for this purpose, and the best routes and schedules for their administration. Similarly, some chemical agents have given faint promise of ameliorating the symptoms and complications of sickle cell anemia even without trying to change the genetic makeup of the affected patient by more drastic measures such as bone marrow transplantation or "genetic engineering." The prenatal diagnosis of Cooley's anemia and sickle cell anemia has been accomplished to permit the physicians to be aware of potential problems before birth and to provide the parents with information about the options that might be undertaken. These procedures, however, are still extremely time consuming, difficult, and not fool-proof. All of these studies require access to expensive equipment, supplies, and trained health care and technical personnel, and only the NIH is in a position to provide the scientific expertise to judge the applications for support and the means by which to accomplish these humanitarian goals.

A well recognized hazard of blood transfusion is the development of hepatitis, but there are several different viruses that can cause this debilitating and sometimes fatal disease. The incidence of hepatitis B virus hepatitis has been reduced by the significant reduction in the use of paid blood donors, but the hazard still exists. Development of an inactivated hepatitis B vaccine that appears to be safe and effective gives promise of providing protection to those most at risk of contracting this disease, and may signal the possibility of developing analogous vaccines to eradicate, or at least very significantly reduce, the incidence of infection with other hepatitis viruses. Again, think of the savings in terms of lost productivity from the morbidity and mortality that can result from hepatitis if this viral disease is effectively controlled.

For many years, it has been known that the manufacture of red blood cells by the human bone marrow is dependent upon a hormone, erythropoietin. This hormone has been studied extensively and its complete structure has almost been identified. Once that objective is attained, it will be possible to synthesize erythropoietin, either in tissue culture or by recombinant DNA technology, in the purest possible form. Not only would the availability of completely characterized erythropoietin permit more definitive studies on how it works, but it may be possible to use it to treat patients, especially those with advanced kidney failure, whose own erythropoietin production has been impaired. Would it not be better to have the patient make his or her own red blood cells rather than depend upon the transfusion of blood from another person with the inherent potential hazard of a transfusion reaction or the transmission of hepatitis?

These are just a very few examples of the kinds of projects with which the NHLBI and the NIADDKD have been concerned, and that really must be continued to permit the full exploitation of their potential usefulness. Both Institutes, along with the NCI, have long supported such research. The development of successful groups and laboratories to carry out such research takes time and money. One of the recent issues of major concern to the biomedical community has been the continuing uncertainty about the stability of research funding. Recognizing the need for sacrifice and fiscal constraint from all parts of the American society, we would, however, like to emphasize the danger of a penny-wise-and-pound-foolish policy that would result in the starting of such programs and their discontinuation on short notice before their full potentials have been realized. There are, currently, many new and competing renewal research grant applications that have received approvals with high priority scores from the initial review groups (study sections) that are awaiting funding because of the absence of a firmly approved Fiscal 1981 appropriation for the DHHS and the NIH. Absent favorable action in the very near future, some of the laboratories will be faced with the need to terminate highly skilled and well trained technical personnel and the reassignment of professional personnel to other duties with the loss of invaluable past experience and the potential for future advances.

Finally, let me comment on the need to continue to train an adequate number of biomedical scientists, both physicians and Doctors of Philosophy, in the fine art of research. Young men and women still have new ideas that the "old timers" have not thought of and that they will probably not have the energy to explore. The progressively escalating costs of medical education have discouraged many young physicians from taking the time to obtain the necessary research training to permit them to explore their original ideas. Rather, they wish to complete their training as quickly as possible so that they may begin to repay the debts that they have incurred. The research training grants have provided the mechanism, at relatively modest cost, to permit those with the motivation to pursue academic research careers to receive the necessary training and to begin to try out their ideas. The few thousand trainees now supported will go on to become the leaders in biomedical research five, ten, and fifteen years from now. Do not discourage them further by suggesting again that support for research training should be reduced, but maintain the commitment that has been made to provide a continuous, though limited, supply of future biomedical scientists for our children and their children.

My colleagues and I in the hematologic community wish to thank you, Mr. Chairman, and the members of the Subcommittee for your patience, attention, and consideration of our presentation. Your generous support in the past has made possible countless contributions to the improvement of human health. We can assure you that the research work proposed for the near and distant future will be done by those who have been trained to do it if you will only recognize the past accomplishments and will provide us with the means to go forward.

STATEMENT OF JANICE PARADISO

Thank you for permitting us to testify today in behalf of appropriations for research and care in Cooley's Anemia.

The Cooley's Anemia Foundation has appeared before this Committee for four years now, and we are grateful for the attention you have given to our proposals, and for your action.

Because you have heard our requests so often, and we know you and your staff are knowledgeable about the disease, we would simply like to put the attachment to this testimony describing Cooley's Anemia into the record.

We have four recommendations to make to you today, which result from the history which you have helped to write. Permit me to recap that history quickly: Three years ago language was inserted in your bill report calling for an extensive survey on research, care, and epidemiology of the disease, a survey which had never been done before. The National Heart, Lung and Blood Institute understood this survey, and they did a superb job. Two years ago report language called for an education program for patients, families and the public at large, to cause preventive medicine to become active in this field. Again the National Heart, Lung and Blood Institute responded, and have created two booklets which are now being widely used in an educational program for the families at risk. For your information, I would like to give you copies of both educational pamphlets prepared this last year by the NHLBI. We are deeply grateful for that assistance. Also, two years ago the Fderal agencies were requested to convene a meeting to determine whether a program of Federal aid could be developed within present authorities to provide patient care for victims of the disease.

We are pleased to tell you that in the last several months the Maternal and Child Health program in the Health Services Administration of the Department of Health and Human Services has begun to receive proposals from the New England area and from the New York area to establish screening and care programs. While it is yet unclear what the extent of these programs will be, and the methods that they will employ, we have been following the initial movements closely, and generally are quite supportive of the efforts being made. In the New England program, the states of Massachusetts, Connecticut and Rhode Island are involved, and in the New York program, the cities of New York City, Buffalo and Rochester primarily would be involved.

You may recall that your bill report language of last year supported the findings of the report of those Federal agencies which did the survey, which indicated that "The consensus was that sections 503 (2) and 504 (2) of Title V of the Social Security Act provided the most feasible and appropriate administrative and legislative vehicles through which aid to States could be provided for Cooley's Anemia patient care."

We understand that proposals are now being entertained under the auspices of the so-called "Reserve B" and "MR" funds of Section 301. It is our further understanding that if the FY 1981 funds are permitted at the House-passed level, and if there are FY 1982 funds at a reasonably increased level, these two projects can go forward, and the Cooley's Anemia patients may receive care.

We hope, Mr. Chairman, that you will provide the necessary funds to assure that these proposed New England and New York care programs may move forward. That is our first recommendation, Mr. Chairman, that the "Reserve B" and "MR" funds be made available at the appropriate levels to carry out that program.

Secondly, Mr. Chairman, we recommend that you consider favorably our concept that these funds, now being proposed to be placed under the block grant programs, either receive an exception to that program, or that sufficient instructions are written in your bill report to assure that there will not be state slowing of the forward movement of the program while the use of funds is debated. You can see the problem, of course: the New England proposal will be a three-state proposal (a large number of Americans of Italian, Greek and other national groups susceptible to Cooley's Anemia live there) and such a program can proceed well under coordinated Federal action, but probably less well under independent state direction by Massachusetts, Connecticut and Rhode Island. Of course, the problem with New York State might be less severe, but nevertheless we can receive no assurances that that State will direct the expenditure of the monies it receives to Cooley's Anemia programs as the Federal agency would do.

There are two other recommendations we make. They involve the National Institutes of Health. Two of the Institutes currently provide research funds in the area of Cooley's Anemia. We know that because of the nature of the hematologic sciences, Cooley's Anemia serves as an excellent research model because of its applications in science to other blood diseases. The National Heart, Lung and Blood Institute has long had extramural and intramural programs dealing with this disease. We report to you that the relationships of this Institute to our Foundation have, simply, been excellent. We owe a deep debt of gratitude to the leaders of that Institute, and to Dr. Chernoff who heads up the blood research effort there, and to Dr. French Anderson who has devoted so much of his life and career to the search for causes and cures for the disease.

Likewise, the National Institute for Arthritis, Metabolism, and Digestive Diseases does a great deal of basic research in the field of hematology, and has been most helpful in work in Cooley's Anemia.

These Institutes, we believe, have led the way, as has the NIH generally, in providing great advances in our field. We recommend, then, that the FY 1982 level for the NHLBI, including training, be set at $625 million, and we recommend that for NIAMDD the figure should be $409 million. We understand that those are also the figures suggested by the American Society for Hematology, and we support them.

Thank you, Mr. Chairman, for the assistance you have given us in the past. We look forward to working with you and your staff in the future. We will be pleased to answer any questions you may have.

INFORMATION SHEET

COOLEY'S ANEMIA

Cooley's Anemia is the name commonly used to describe the severe form of a hereditary disease of the blood. It was Dr. Thomas B. Cooley, an American physician, who described this as a separate and specific type of blood disease about 1925.

This disorder occurs most commonly in individuals whose ancestors were natives of the countries surrounding the Mediterranean Sea. In the United States patients are of Italian, Greek, Turkish, Southern France, North African, Chinese, Spanish, Irish and Israeli descent.

The disease, also called Mediterranean Anemia or Thalassemia, is inherited according to Mendelian laws and it is known that the severe form (Thalassemia Major) occurs in a child born of parents both of whom must be carriers of the trait. According to this accepted concept, approximately one quarter of all children born of marriages of two individuals with the trait, will have the severe form of the disease. Another twenty-five percent of the offspring will be perfectly normal, and fifty percent will be carriers themselves. Any such hereditary situation, of course, is valid in statistical sense only, and may not be referable to one family where instances are known of only one affected (anemic) child out of ten, or the reverse, where three out of three children may be affected.

Because individuals with the trait or minor form of the disease are not in any significant way handicapped physically, and in whom the only manifestation may be detectable changes in the size and shape of the red blood cells, it is of great importance to distinguish between Thalassemia major and Thalassemia minor. Individuals with Thalassemia minor have a normal life span and enjoy normal health, whereas individuals with Thalassemia major may succumb to the disease in a matter of one or two decades. The trait never increases in severity or converts to the severe form of Cooley's Anemia.

Thalassemia major usually becomes manifest during the first year of life. Both sexes are equally affected. The earliest signs may be pallor, listlessness, loss of appetite, and irritability. Examination of the patient, by a physician, usually reveals an enlargement of the spleen and liver to some degree, pallor of the skin and mucous membranes, and sometimes a slight degree of jaundice (yellow coloration) of the whites of the eyes. Blood examination will usually show typical changes in the shape, numbers of the erythrocytes (red blood cells), and a variety of alterations from the normal in special properties of the blood cells, in addition to a severe anemia.

There are probably several defects which lead to the anemia. For example, there undoubtedly is a reduction in the rate at which red blood cells are formed in the marrow and released to the blood vessels. Those cells that are produced are defective in that they do not survive in the blood vessels for more than 1/3 to 1/2 of the normal life span of red cells, which should be about 90 to 120 days. There are complications which develop in certain individuals which further reduce the rate of blood cell production and survival time of the formed cells. In these patients the greatly enlarged spleen may be the cause of this additional hindrance.

As a result of the chronic state of anemia, the children with this disease are greatly handicapped. Bone growth is poor - they are, therfore, usually small for their age. Because of abnormalities of the bone marrow, there are alterations of the skull and other bones, so that a characteristic facial expression is found, which give many of these children the appearance of being related. The bones are more fragile than normal, and fractures occurring almost spontaneously are quite common. The anemia causes easy fatigability, and a lack of pep and energy. Frequent nose bleeds is a common finding in many patients. When anemia is severe, low grade fever may be noted. There is no particular increase in susceptibility to infections.

At present the only effective treatment is the proper administration of blood transfusions to alleviate the constantly recurring anemia. There are other specific treatments for various complications of the basic disease.

There seems to be a continuous spectrum in the degree of severity of the disease from those children who require blood transfusions as often as once a week to those who rarely need transfusions. Some children die within a few years and others are known who are alive in their twenties. There is no known cure.

STATEMENT OF DR. BENJAMIN F. HAMMOND, MEMBER AND PAST PRESIDENT OF THE AMERICAN ASSOCIATION FOR DENTAL RESEARCH

Dr. HAMMOND. Thank you, Mr. Chairman. I am appearing today on behalf of the American Association for Dental Research, and I appreciate very much the opportunity to present testimony before you concerning the fiscal 1982 budget for the National Institute for Dental Research, and I respectfully request that the full text of the testimony be included in the record.

Senator SCHMITT. It will be so included, without objection.

Dr. HAMMOND. The membership of the American Association for Dental Research includes about 3,000 scientists, most of whom come from universities, from industrial laboratories, hospital and various research institutes. Our major goal, our common interest, has been to determine the major causes of the dental diseases and specifically how we can protect, prevent, and control these diseases.

I think the significance of these goals can best be understood if we consider the oral health problems of this country, and I think a few examples might help. In the recent report from the Surgeon General's office it was pointed out that approximately—no approximately—more than one-third of our children, American children, in this country lose one or more permanent teeth before they are 17 years old as a result of dental decay or periodontal disease.

That 24 million Americans are adentular, that is, they are completely without teeth, and in the elderly group, people over 65, that roughly 50 percent of these people are adentulars. I think it's also interesting to note that there are about 127 million people who have one or more forms of periodontal disease. All this in spite of the fact that the American public spent, last year, in excess of $14 billion for dental care, and that figure does not include the additional losses in income due to the fact that they had to stay away to get dental treatment.

This is a situation which doesn't have to be, and it's the position of the American Association for Dental Research that we are in a position now to do something about it. It's unusual to use the term "breakthrough," or to say that an institute or a group of scientists is at a point of reaching a breakthrough position. I think we are at this point and in a few minutes I would like to give some of the reasons why I think this is an appropriate thing to do.

My specific point has to do with the cost effectiveness of the proposals for funding dental research. I do not consider that an increased expenditure for dental research represents a handout. I consider it an investment in the future of our country, and I believe that the proposals that are now underway, the research that is now being done, will allow this to occur.

There have been a number of facts that are presented in the testimony, but there are two pieces of arithmetic that I would like to put as preface to my remaining remarks. The first is a repeat of the figure of $14 million that the American public has spent for dental care. The second is the information, the fact that less than one-half of 1 percent of this amount was spent for dental research last year. We think that's an inappropriate way to solve the problem.

I think the past record of the National Institute of Dental Research with respect to two main areas, dental caries and periodontal disease are exemplary. The record is exemplary. We have, for example, been able to reduce considerably the incidence of dental caries in the population. Reductions of up to 60 percent of dental caries were observed in a recent report that will be presented this week at the meeting of the International Association for Dental Research.

We know more about this infectious disease, I submit, than any other disease known to man. We can describe the processes that occur down through the molecular level, and I think the prospect of a caries vaccine is a very real one. Such a vaccine, as indeed a vaccine for periodontal disease, will not eliminate caries completely, but I think the combination of fluoridation and these other procedures will materially affect the dental health of our country.

In conclusion, as I see the red light is on, I would like to say that the American Association for Dental Research supports fully the fiscal 1982 budget of the National Institute of Dental Research at $85.6 million. I would be happy to try and answer any questions about this.

Senator SCHMITT. Just one. Doctor, do you feel that there is sufficient examination of the dietary influences on dental decay and on the susceptibility to caries and periodontal disease?

Dr. HAMMOND. No; I do not, and I think there is an impressive body of information that is available at this time to indicate that dietary modifications can influence the cause of periodontal disease. Certainly the same thing has been true with great detail about dental caries, specifically with the effect of sucros on the diet, but there is a considerable amount of information that still remains about proteins that has not been looked into and about the interactions of other various foodstuffs that are normally taken in. I think the aspect of behavioral modifications and the diet are also an important aspect and one that is listed in the testimony that was presented.

Senator SCHMITT. But it's a lot tougher to modify behavior than it is to give a vaccine coated sugar cube.

Dr. HAMMOND. That is quite correct, and that is one of raison d'etre behind the vaccine because we realize the great difficulties in modifying behavior. If it was possible to have a vaccine very much as in the case of smallpox, it's been possible to eliminate, almost eradicate, virtually smallpox from the face of the earth, whereas dietary modifications as has been known in Scandinavian studies, are extremely difficult to do. That's the reason for, I think, a multifaceted approach to the caries problem and also to periodontal disease.

Senator SCHMITT. Thank you, Doctor. Senator Rudman?

Senator RUDMAN. No questions.

Senator SCHMITT. Thank you very much.

Dr. HAMMOND. And I'm drinking some of the Washington fluoridated water.

Senator SCHMITT. I almost asked you that. [Laughter.]

[The statement follows:]

STATEMENT OF DR. BENJAMIN HAMMOND

Mr. Chairman, my name is Dr. Benjamin Hammond. In addition to being Professor and Head of the Department of Oral Microbiology at the University of Pennsylvania, I am a dentist with a Ph.D. degree in microbiology, and do research in oral diseases. I am appearing today on behalf of the American Association for Dental Research (AADR) of which I am a member and Past President. We appreciate having this opportunity to present testimony regarding the fiscal 1982 Budget for the National Institute of Dental Research. We respectfully request that the full text of our testimony be included in the record.

The membership of the AADR includes about 3000 scientists in a variety of basic science and clinical disciplines located in universities, research institutes, hospitals and industrial laboratories across the country. Our common aim is to determine the causes of the major diseases which affect the teeth and orofacial region of the body, and to seek ways of controlling them. We are pleased to make the resources of our Organization, which is headquartered here in Washington, available to members of Congress and their Staffs.

The scope and significance of dental diseases are not well understood, as evidenced by the following statement of the Surgeon General of the United States in the foreword to his report "Healthy Children -- Children's Oral Health":

> "Diseases of the teeth and the adjacent oral structures are among the most common maladies affecting human beings. Perhaps because they are so common and are seldom life-threatening, such diseases frequently do not receive the attention they deserve, either from individuals or from health officials, legislators, health planners or others concerned with improving the Nation's health status.
>
> "For most persons in the United States, oral diseases or their sequelae are on a continuum from early childhood to death. Virtually every person experiences tooth decay. Most persons also develop disease in the adjacent oral structures, the most common being periodontal disease. Without proper treatment, dental caries and periodontal disease result in tooth loss. By the time children reach 17 years of age, more than one-third have lost one or more permanent teeth. Among the elderly, nearly one-half are edentulous, that is, without any of their natural teeth."

Last year the American public spent about 14 billion dollars for dental care. Additional income losses were experienced by individuals as a result of time lost from work in order to receive treatment. In spite of this huge expenditure of time and money, over 24 million Americans are totally without teeth because of oral diseases. This really does not have to be.

It should be noted that the National Institute of Dental Research, which has been charged by the Congress to reduce and, where possible, eliminate oral and dental diseases, is the smallest of the NIH Institutes, and it has not grown substantively since 1973. At the present time, less than half of 1% of the cost of dental care is spent on research. It is the position of the American Association for Dental Research that the expenditure of public funds for dental research is an investment in the future and not a hand-out. It is through this investment in basic and clinical research that cost-effective ways to control and prevent oral diseases will be found.

Current Status

In spite of the fact that funding for dental research has been relatively limited, significant progress has been made in the understanding and development of means of controlling orofacial diseases. This is illustrated by the following examples in just two diseases, which are the major ones affecting man -- tooth decay and periodontal or gum disease:

- Results of Caries Research - Data are now accumulating showing that a substantial reduction in dental caries has been occurring for at least the last ten years, especially among children and teenagers, which we believe is the result of multiple uses of fluoride and improved dietary and oral hygiene habits. In areas with water fluoridation, reductions of 50-60% are common. Even in non-fluoridated areas, however, there have been reports of up to a 50% reduction when comparisons are made between 1958 and 1978. These data will be reported and discussed at our annual dental research meeting beginning this week in Chicago. A number of recent studies also being reported at this meeting attest to the efficacy of fluoride mouthrinsing (30-35% reduction) in water-fluoridated areas. With an augmented effect, the various combinations of fluoride application could produce caries reductions of over 75%. Other factors contributing to this reduction are improved oral hygiene and diet; however, behavioral studies are needed to assess these parameters thoroughly.

- Periodontal Diseases - These diseases are the main cause of tooth loss in adults. During the process, gums and bone around the teeth are destroyed. Usually the teeth must be removed and indeed sometimes practically fall out. Dental research has shown that periodontal disease is fundamentally a result of dental plaque, which is bacterial in nature. Some of the microorganisms thought to cause periodontal disease have been identified, and the mechanism by which they produce their undesirable effects is beginning to be understood. From a preventive and therapy standpoint, methods have been tested which have demonstrated that the early stage of the disease --gingivitis-- can be prevented, and the more advanced stages can be arrested.

Future Areas for Dental Research

1. The basic laboratory work on completing our understanding of dental decay and the development of preventive and treatment techniques now in progress needs to be maintained so that the momentum in bringing this ancient scourge under control is not lost. This means that there is also a need for more clinical and behavioral studies to ensure maximum delivery of this technology to the public.

2. The fundamental studies on periodontal disease now well-initiated should continue to move forward to more clearly define the organisms responsible and the modes by which they create their destruction. The rapidly-expanding

need at present is to carry over these laboratory studies into human clinical studies to test concepts, diagnostic methods and control procedures.

3. Even with the prospect of controlling these two major oral diseases, the need for dental materials will remain, to correct damage already incurred as well as to serve the population which will inevitably fall outside the benefits of dental research developments. The ever-spiralling high cost plus the limited durability, and, in some cases, availability of dental materials requires increased research to identify new restorative materials and devices which will be less expensive, more durable and more natural in appearance. Without such research, the cost of dental care may eventually move beyond the reach of the average family. In fact, the cost of the research has long been largely beyond the reach of the private sector.

4. Many other areas of need also exist but will not be detailed, such as oral ulcers, cleft palate, developmental problems, and improved X-ray techniques.

Many aspects now emerging from dental research need study in the clinical setting to apply the knowledge toward the clinical management of a number of orofacial diseases, particularly dental decay and periodontal diseases. Clinical research projects should be developed and funded for a sufficient period of years to ensure the development of a core of clinical investigators sufficient to allow for a subsequent transition of projects from the laboratory stage to the human testing phase.

In light of the magnitude of the problem of oral diseases, and the potential for significant breakthroughs in treating and preventing these diseases, we respectfully recommend a funding level for NIDR of $85,600,000 in Fiscal Year 1982. It should be noted that this figure includes continued support of research training, which is vital for a sound biomedical research program. Unless we can continue to attract the best and brightest young minds, this Nation's research program, which is second to none, will slip, and the citizens of this country will suffer the consequences.

The American Association for Dental Research believes that a successful biomedical research program contains many elements -- namely, basic research, training activities, funding of clinical research, and technology transfer activities. Unless all of these elements are funded in a balanced manner, the taxpayer underwriting this enterprise will not reap the benefits of his investment. This is important, Mr. Chairman, and we urge the members of this committee to consider these facts as they mark up the 1982 Appropriations bill.

I will be happy to answer any questions.

SUBCOMMITTEE RECESS

Senator SCHMITT. Thank you very much. The subcommittee will stand in recess until 9:30 tomorrow when we will meet again in this room to hear further public witnesses on the Federal health programs.

[Whereupon, at 3:20 p.m., Monday, March 16, the subcommittee was recessed, to reconvene at 9:30, Tuesday, March 17.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

TUESDAY, MARCH 17, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:30 a.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Warren Rudman presiding.

Present: Senators Schmitt, Rudman, Hollings, and Inouye; also present Senator Mathias.

NONDEPARTMENTAL WITNESSES

SUBCOMMITTEE PROCEDURE

Senator RUDMAN. The subcommittee will come to order. Today we are going to continue with testimony from public groups interested in Federal health appropriations.

We have a very ambitious schedule this morning, so of necessity, the time allotted to witnesses this morning is limited. In your testimony, I hope you will give your highest priorities for funding among the major program areas. Once we have completed the fiscal 1982 budget, we plan more deliberate a look at the programs under the subcommittee's jurisdiction and of course we will prepare in that way for the 1983 hearings.

First we plan to finish testimony which we began yesterday relating to the National Institutes of Health. All the witnesses of the agency will be completed this morning.

To start off today we have a panel on the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases. Your full statement will be included in the record, so we would appreciate it if you would only highlight your statements this morning.

If that panel would like to come forward and be seated at the witness table. Your prepared statements will be printed in their entirety after your oral presentations. Please proceed.

We only have for your entire panel about 15 minutes. I know that is not adequate but I hope you understand that it is not lack of interest on the subcommittee's part, but a lack of time considering our schedule. I can assure you that we will very carefully look at your submitted statements. I would like you to decide among yourselves in which order you will proceed and will you please identify yourselves fully for the record and also for my information.

You may proceed and the yellow light will show when you have 1 minute left in your time.

STATEMENT OF DR. JOHN T. SESSIONS, JR., CHAIRMAN, COMMITTEE ON GOVERNMENT LIAISON, AMERICAN GASTROENTEROLOGICAL ASSOCIATION

Dr. SESSIONS. I am John Sessions, M.D., professor of medicine at the University of North Carolina. I represent the over 4,000 members of the American Gastroenterological Association and we are concerned with the treatment, prevention, and research relative to those diseases.

Senator RUDMAN. You may be seated if you prefer and bend that microphone toward you.

Dr. SESSIONS. Can you hear all right?

Senator RUDMAN. I think if you were seated and move that right up close to you it might help.

Dr. SESSIONS. We appreciate the time to testify. I want to therefore make four points.

First of all, the organization that I represent would like to urge that the proposed fiscal year 1981 rescissions by the administration not be effected. No. 2, that NIAMDD be funded in 1982 at the level of $410 billion.

Our third point is that we would like to have some bill report language that would encourage the Institute to support two items that were unanimously supported in authorizing the legislation at the end of the last Congress.

The first of these is the establishment of a national digestive diseases advisory board. These are present for other elements within the Institute.

The second one is the National Digestive Disease Education and Information Clearing House. We need the bill support language to help assure that these proposals by the Congress are carried out in the Institute.

And finally, please try to support research training at a level sufficient to insure our future. There is a great deal of excitement in our area at the present time because of new technology and new opportunities to study. If we destroy this by not supporting young investigators, we are fearful for the future.

Thank you very much Senator Rudman.

Senator RUDMAN. Thank you very much for your very precise statement. We appreciate that.

STATEMENT OF DR. GILES BOLE, PRESIDENT, AMERICAN RHEUMATISM ASSOCIATION

Dr. BOLE. I am Dr. Giles Bole, president of the American Rheumatism Association speaking in behalf of the fiscal year 1982 budget supported by the Arthritis Foundation of American Rheumatism Association.

In my submitted testimony there are five priorities. I will speak to three.

One of those is maintaining momentum, research in our field, and as just stated, continuous support of young investigators is critical. We also provide for the continued growth of multipurpose arthritis centers, the success of which I think is well established, one of which is in your home State.

And third, provide some impetus to research and training in the field of rheumatic disease that relates to children. There are 250,000 children with several forms of the disease. I will not take the time to enumerate the progress on research in the field. It has been exciting the last several years. It includes approaches to the detection of genetic flaws that can produce certain forms of inflammatory disease; research of certain abnormalities of the immune system disorders that apply to fields beyond; and as noted, a need for research on childhood problems.

It is extremely important, I think, to recognize that osteoarthritis and the chemical knowledge of this important illness is not available to be exploited.

I will note that I must speak with some disappointment about the cluster support with the NIAMDD. Although I know there has to be rescission support, the funding at the level of $410, I think it is also important to examine the research qualities within the various clusters.

I would last close with a strong support for the young investigator. If there is a gap in the training of those individuals, we will have a gap in the health care system. I thank you very much for the opportunity to comment.

Senator RUDMAN. Thank you very much, Dr. Bole, for your testimony.

STATEMENT OF JASON ROBERTS, VICE PRESIDENT, GOVERNMENT RELATIONS, JUVENILE DIABETES FOUNDATION

Mr. ROBERTS. I am Jason Roberts from the Juvenile Diabetes Foundation. I am father of an 18-year-old son who has had diabetes for 9 years, so I am here to voice my concern for the organization and all diabetics throughout the country.

We have several concerns. Basically, Senator Schmitt was quoted recently in the Washington Star saying, "We must focus far more on research that will lead to prevention of diabetes." We agree with this and that is why we are here.

We are concerned about the training funding being cut back to the point that within a 4-year span there may be no dollars of training at all. I can't address too much about the different breakthroughs that have occurred in diabetes in recent years. They have been tremendous and we would like to see them continue.

I have with me Dr. Clark who is with the American Diabetes Association and he can continue on this.

STATEMENT OF DR. CHARLES CLARK, DIRECTOR, DIABETES RESEARCH AND TRAINING CENTER

Dr. CLARK. I am Dr. Charles Clark, director of the Diabetes Research and Training Center at Indiana University, and also chairman of the Governmental Committee of the Diabetes Association.

I would like to speak to retaining momentum of the research which has gained so much for the past few years. OMB says that 9½ percent is the inflation rate in science and technology. We think in order to retain momentum, the increment in research funds should approximate that 9½ percent. We also feel it is very important to maintain research training and we oppose the rescission in the area of diabetes, that particularly focuses on cutting back on training. And if we cut back on training, we are talking about eliminating the ability to do research in the future. Thank you.

Senator RUDMAN. Thank you very much.

STATEMENT OF DR. BERGEIN F. OVERHOLT, AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY

Dr. OVERHOLT. My name is Gein Overholt, a practicing gastroenterologist in private practice, and I represent the American Society for Gastrointestinal Endoscopy, a society of over 2,500 physicians who have taken special training in the use of diagnosis of treatments of diseases of parts treated with surgical intervention, such as the colon.

Our society would also like to emphasize the four points made previously. First, the continuation of NIH research training programs so that we can support our young researchers.

Second, the funding of NIAMDD at the level of $410 million is strongly encouraged.

Third, we would like to oppose rescissions for the fiscal 1981 budget and have them rejected by the committee.

Last, we also support the bill language that hopefully would be supported by this committee, that would support the National Digestive Disease Advisory Board and National Clearing House and Information Center. Thank you.

Senator RUDMAN. Thank you very much.

STATEMENT OF GAIL E. RIGGS, PRESIDENT, ARTHRITIS HEALTH PROGRESSIONS ASSOCIATION

Ms. RIGGS. Good morning. I am from Tucson, Ariz., associate director of the Southwest Arthritis Center. I am also president of the Arthritis Health Profession Association of the American Arthritis Foundation and I have been an arthritis patient for 35 years.

Today I speak with both professional and personal knowledge about arthritis. I would like to first of all thank the Federal Government for the support of nurses and allied health professionals over the years in helping us get our organization going so we can impact on 31 million arthritis patients.

The second point I would like to make this morning is that the multipurpose arthritis centers funded under the arthritis cluster right now are vitally important to our mission in training allied health professionals and that, consequently, those people's impact goes directly to people who are severely crippled by arthritis.

I would like to also stress the importance of these centers in providing patient education to the many young people—the 250,000 children who have arthritis, and the 6 million young adults aged 20 to 40 who have rheumatoid arthritis. At a time when we are looking at productivity it is very important that we educate these people. I would like to give you an example, if I may.

Today, I personally could be on disability, receiving $10,000 a year. Instead, I am returning to the coffers $12,000 a year in taxes. In 20 years from now, as 1 person out of 6 million, I will have returned $500,000 back to the Government. Thank you very much.

STATEMENT OF DR. RICHARD M. FREEMAN, PRESIDENT, NATIONAL KIDNEY FOUNDATION

Dr. FREEMAN. Senator Rudman, my name is Dr. Richard M. Freeman, president of the National Kidney Foundation, and also represent the Intersociety Committee for Kidney Research.

I want to make four points. First, I want to thank you for the progress that has been made in the treatment of patients with kidney disease. Nowadays, those who are elderly and those in racial minorities and women have done very well from the standpoint of renal care. We, however, project that vacancies in academic nephrology will reach a figure of 483 in 1984.

There are many young investigators who are abandoning their careers because of lack of support in research. We think that the individual investigator-initiated research is the highest priority. We plan to continue to support that in particular.

And we finally think that growth rather than constriction in renal research is necessary if we are to take care of some of the costs of end-stage renal disease.

Senator RUDMAN. Dr. Freeman, it is my understanding that there has been a breakthrough in the past year or 18 months which is now being tried more in the field.

Dr. FREEMAN. It is a procedure called continuous ambulatory kidney dialysis, which means more patients than before are being treated in the home with dialysis. We think it is an important breakthrough, but perhaps not a panacea.

Senator RUDMAN. Is that a process which medically is as satisfactory as the normal dialysis people have to undergo?

Dr. FREEMAN. It has the problem that peritonitis tends to occur and it limits effectiveness. But, medically, in 80 to 90 percent of the patients, it is satisfactory.

Senator RUDMAN. What is the relative cost of that on an annual basis?

Dr. FREEMAN. The costs, unfortunately, are comparable, partly related to complications of peritonitis where there is more hospitalization than you expect. But the potential is great for cost decreases.

Senator RUDMAN. Is the research in this area something that your foundation has been in the forefront of?

Dr. FREEMAN. We support analysis in that area as well as hemodialysis.

Senator RUDMAN. Thank you very much.

STATEMENT OF DR. JOHN H. SADLER, PAST PRESIDENT, RENAL PHYSICIANS ASSOCIATION

Dr. SADLER. I am John H. Sadler, and I speak for the Renal Physicians Association, which is a clinical group of transplant surgeons, pediatricians, and neurologists involved in the treatment of kidney disease. We are not primarily investigators and we are not asking for funds for our members, but for our patients and potential future patients.

We support the statement that Dr. Freeman has made on behalf of the committee. And we emphasize—although we take great pride that we have delivered great care to people without kidney function at a high level, with a high degree of rehabilitation and quality of life and restrained the cost of that care—that we believe this is a stopgap measure. The future depends on research. The investigation to provide the knowledge to lessen the need is where the real economy lies.

We wish to emphasize also that the loss of tomorrow's investigators won't be felt immediately, and can't be corrected quickly. And the support for research training is essential and must never be less than first priority. We really believe that we cannot take chances with our future in spite of great stresses we have on the economy today. Thank you.

Senator RUDMAN. Thank you very much, doctor.

STATEMENT OF BETSY ASTOLFI, REPRESENTATIVE, AMERICAN BRITTLE BONE SOCIETY

Ms. ASTOLFI. I am Elizabeth Shields Astolfi, and I am here as a representative of the American Brittle Bone Society, a support society for the brittle bone diseases, especially osteogenesis imperfecta and osteosis.

The two points we want to make are that the National Institutes of Health be directed to equalize paylines among the various extramural research program areas of all Institutes so that high-quality proposals for the study of osteogenesis imperfecta and related bone diseases will at last be able to receive fair and equal consideration—on the basis of scientific merit—in competition with other research proposals.

Second, that appropriations for the NIH be sufficient at least to maintain and if possible to increase, the current level of support for biomedical research in terms of paylines and percentages of approved grant proposals that can be funded. Specifically, it is recommended that the fiscal year 1982 appropriation for the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases be approximately $409 million in order to provide a minimal level of growth for the many crucial areas of research funded through that Insitute.

Also, that Congress express to the NIH its awareness of and concern about the need to emphasize implementation of the following research priorities relating to osteogenesis imperfecta and other brittle bone diseases:

A. Additional basic research involving more detailed characterization of the molecular structure of collagen in various bone diseases, and more complete ascertainment of the composition of non-collagenous proteins as well as various types of collagen within bone matrices.

B. Application of the most current research techniques to investigation of the genetic abnormalities of inherited bone disorders at the DNA level.

C. Additional support for clinical facilities and the possible development of an information exchange and registry for the collection of human clinical materials related to various bone diseases.

Finally, greater use of other support mechanisms in addition to the standard research grant—including training grants and intramural research on osteogenesis imperfecta and related bone diseases.

Senator RUDMAN. Thank you very much.

STATEMENT OF SUZANNE ROSENTHAL, CONVENER, COALITION OF DIGESTIVE DISEASE OGRANIZATIONS

Ms. ROSENTHAL. I don't know if it's appropriate for me to welcome you to your new committee, but I am pleased that you have taken on this responsibility. I am Suzanne Rosenthal. I am here today representing the Coalition of Digestive Disease Organizations which is a new gathering of organizations directed to concerns involving all of the digestive diseases; and here we are talking about 50 different disorders and major diseases that are the first cause of hospitalization in the United States, costing the Nation some $17 billion annually.

We are particularly concerned this year because of the obvious feelings of restrictions concerning budget in the health field. Our major concerns result from the recommendations that come out of the National Digestive Disease Commission, which had in fact taken place about 4 years ago.

Since that time the movement has been minimal. We did finally have authorization last year for the Digestive Diseases Advisory Board and as yet it has not been funded.

We did have authorization for a clearinghouse and as yet it has not been funded anywhere to the degree that other clearinghouses in the similar Institutes have been funded. Those funds that have been assigned have come from the research dollars.

We have made some significant progress in digestive disease, with the hepatitis B vaccine, with new interest and encouragement in the field of pediatric liver disease with concerns of liver transplant. We are not making any progress in terms of help from the Government to complete the partnership of the lay/medical community on a voluntary basis.

The digestive disease field, certainly in terms of any organized effort by the Government has been minimal. And those recommendations that came out of the Commission would have, for the first time, set forth the beginning of a new national plan for attack against digestive diseases.

If you could see your way clear, the committee could see its way clear, to just focus in on those authorizations that passed last year, to investigate the appropriations that have been assigned and to follow through on those recommendations, we would be, of course, particularly gratified and the hundreds of people who have testified 4 years ago are still waiting for some sound, some positive result of the combined efforts in presentation of the testimony. Thank you for the extended time you allowed me.

Senator RUDMAN. Thank you. Let me simply say that we thank you all very much for taking your time to come here and testify and give us your statements—statements which will be given weight, I can assure you. This subcommittee, obviously, is under intense pressure due to the economic situation in this country. I am sure you are all as aware of that as anyone.

But let me tell you that I am sure that our subcommittee chairman, Senator Schmitt, and all of us are all personally mindful of the great human suffering that is behind these cold facts and statistics and words. All of us, I am sure, on this subcommittee, have friends who have children or loved ones who have suffered from some of the very things you are talking about this morning and I can tell you that I am sure that each member of the subcommittee will try to do what is the most equitable and most generous under all of the circumstances. We can say that to you, and not much more, but we can say that. Thank you for being here.

[The statements follow:]

STATEMENT OF DR. JOHN T. SESSIONS

Mr. Chairman, I am John T. Sessions, Jr., M.D., Professor of Medicine, Division of Digestive Diseases and Nutrition, University of North Carolina at Chapel Hill. I represent the American Gastroenterological Association which has over 4,000 physician members who are concerned with the improvement of patient care and research in the field of digestive diseases.

The field of digestive diseases is burgeoning with research opportunities, and a sense of excitement regarding these opportunities exists throughout the field. The truly remarkable advances in recent years in all areas of biomedical research, including the new biotechnology, have added enormously to our knowledge and to the research and patient care tools with which we work.

It was truly fortuitous in terms of the development of our field that four years ago the Congress established, in law, the National Commission on Digestive Diseases, to determine where the field in general had been, where it was at the time the law passed, and what were the prospects for the future. Over 400 lay persons and gastroenterologists all across the nation participated in this effort, and the plan finally laid out by the Commission will help to determine our future work for many years to come.

We are very grateful that the Congress received the Commission's recommendations so well, and acted so swiftly on those which required congressional action.

You will recall that last year bill report language carried words of praise for the report that was developed, and urged the NIAMDD to move forward on those research aspects of the report which required no further authorization in law.

You will recall that at this stage in your appropriations deliberations last year, we reported to you that the necessary authorizing legislation, which the Commission identified as being needed to more systematically carry forward the plan, was well underway in both the House and the Senate. Unfortunately, the authorization legislation, which I will describe shortly, became part of a larger biomedical research bill. That legislation differed profoundly, in terms of public policy regarding the National Institutes of Health, in the House and Senate versions. There was no disagreement on the outlines of the digestive diseases portion, but the debate on the total bill slowed passage until the final days of the last Congress. It is significant to note that there were no negative votes against the digestive diseases portion of the legislation at any stage of markup or floor action, and obviously represented a unanimity of view on both the Senate and House sides that such a program should go forward.

We respectfully request this Committee now to provide funding, less than $500,000 total, to carry forward the two small, but important programs that were established, and further that the Subcommittee specifically endorse the use of funds to support these programs in bill report language. We believe that this is necessary because of the possible tightening up on research funding in this Institute this year. I refer here to the National Digestive Diseases Advisory Board, which is similar in structure to two previously existing boards, the Diabetes Advisory Board and the Arthritis Advisory Board, in the same Institute.

Those of us who have been observers of this Institute for some years recognize the vital role that these two boards have played in assisting the Institute in providing a balanced and coordinated research program there. Also, the National Digestive Diseases Education and Information Clearinghouse was also established, to further the information flow to patients and physicians and other health care professionals about advances in digestive diseases.

We have other recommendations to make: We urge this Subcommittee not to accept the proposed FY 1981 rescissions for the NIH, in general, and for the NIAMDD, in particular. These cutbacks, occurring in the last 30% of the year, will cause distortions in the research strategies which will take considerable time to correct. We urge this Subcommittee to fund the NIAMDD at a level of $410,000,000, a figure which the Coalition for Health Funding also supports, in FY 1982.

We further urge that this Committee not agree to cuts in research training. It is difficult to convey the sense of excitement that has been caused by the almost breathtaking advances in recent biomedical research, and research in digestive diseases, in particular. Our young people have the opportunity to understand biomedical sciences that we who are older never had, and we believe that if these young people are given the opportunity for research training, the advances they will cause to occur will be truly remarkable. It would be unfortunate to destabilize opportunities at this time by introducing uncertainties in research funding.

Mr. Chairman, I would now like to describe for you some of the research advances that have occurred over the past year, and those which now seem particularly open to development.

[1] Gallstones continue to be a major public health problem in this country, accounting for about 500,000 operations and about 5,000 deaths per year. Research supported by this Committee has shown that gallstones made of cholesterol may be dissolved, using bile salts which are normal constituents of bile. The interest generated by these studies has led in the past year to two advances. It has been shown in preliminary trials that a commercial emulsifying agent monooctanoin is capable of dissolving cholesterol stones left in the bile ducts after surgery at a rate about twice as fast as bile salts. Equally exciting, it has been shown in the prairie dog, an animal that can be readily induced to form gallstones, that high doses of aspirin strikingly prevent the formation of gallstones, apparently by decreasing the formation of mucus, a substance frequently found at the center of gallstones. We now have a possible means of preventing the formation of cholesterol gallstones in people at high risk such as Indian women or in others whose gallbladders contract sluggishly - for example, during pregnancy. It is readily apparent that the most exciting days for the prevention and dissolution of gallstones lie ahead. Another breakthrough has been the recognition that pigment gallstones, which make up about a third of the total group, are of two chemically different types and apparently have different causes. This exciting epidemiologic information opens new vistas for research in the physical chemistry of gallstones.

[2] Peptic ulcer, a frequent health problem in our country, may well attain greater significance as our society becomes more competitive and less mobile. An NIH grantee has found that premature separation of rat pups from their mother increases their subsequent susceptibility to ulceration of the stomach produced by food deprivation and restraint.

Factors found in the rat mother's milk were protective against these ulcerations. Further, it was found that the increased susceptibility to ulceration of the stomach produced by this environmental manipulation was transmitted to offspring in the next generation. The possible applicability of these findings to the prevention of peptic ulcer are obvious. Insofar as treatment of peptic ulcers are concerned, it has been demonstrated that substances named prostaglandins increase the ability of the lining of the digestive tract to protect itself against ulceration and speeds the healing of ulcers that do develop. These prostaglandins appear to have multiple means for accomplishing these beneficial effects including the stimulation of the stomach to produce an antacid (bicarbonate) and an increase in blood flow to the area which may also provide for protection and faster healing. There remain important basic studies of the physiology and biochemistry of the gastric barrier to digestion that can be performed with our newer understanding of genetics, pharmacology and enzymology. In fact, one of the major research opportunities is to clarify the role of small proteins, peptides, found in the gut and the brain on the secretion, motility, growth and regeneration of the digestive tract.

[3] The major liver diseases of hepatitis and cirrhosis are beginning to yield important information as to their causes and treatments. Viral hepatitis, as a rule, runs a short and benign course. However, a significant percentage of patients, as high as 20% in some groups, either have continuing illness leading to cirrhosis or continue to be infected with the virus, threatening suspectible people that are unwittingly exposed to the patient. During the past year a researcher using recombinant DNA techniques has developed a test for the presence of the hepatitis B virus in liver tissues that is about 1,000 times more sensitive than previous techniques. This new methodology may allow us to recognize patients that continue to be infectious and to understand better the persistence or progression of illness in the patient who has had acute hepatitis. We will now come to know more clearly the role of this virus in acute hepatitis, chronic hepatitis and liver cancer. Cirrhosis of the liver is associated with accumulation of scar tissue. Research in other organs is revealing the factors which cause the production of scar tissue, the mechanisms for normal removal of scar tissue and factors which preserve a balance between these two activities. Much of the progress in this area stems from advances in our knowledge of basic immunology. The development of safer, more selective drugs for modifying immune reactions gives us reason to hope

that we will soon be able to arrest the progress of liver diseases having primarily an immunologic basis. When this fails, we should succeed in transplanting a healthy liver with an acceptable risk and good clinical outcome. The finding of cyclosporin A, the immunosuppressive agent, is a major step forward in this area.

[4] The National Cooperative Crohn's Disease Study, a five-year effort funded by this Committee,has clarified to a large extent the usefulness of the three most commonly used drugs in the treatment of Crohn's disease. The data on the effectiveness of these drugs and their toxicity has encouraged the pharmaceutical industry to synthesize additional compounds that include the most effective and least toxic elements of these drugs. We expect to have new preparations available for clinical testing within a year. One interesting sidelight is that the drug that appears most useful and least toxic for the treatment of Crohn's disease appears to reduce the fertility of male patients. This finding is of special interest because most of the patients are in their early reproductive years. NIH supported research continues to find candidate viral and bacterial agents for the infectious etiology of the inflammatory bowel diseases, Crohn's disease and nonspecific ulcerative colitis. New immunologic techniques and those using recombinant DNA are assisting in the evaluation of these candidate agents.

STATEMENT OF DR. GILES G. BOLE, JR.

My name is Dr. Giles Bole. I am from Ann Arbor, Michigan where I am the physician-in-charge of the Arthritis Division and of the Rackham Arthritis Research Unit at the University of Michigan. I am also the program director of the University's Multipurpose Arthritis Center. I am here to testify today on behalf of the Arthritis Foundation in my role as President of the American Rheumatism Association of the Foundation.

The Arthritis Foundation has five priorities with respect to biomedical research and training in FY 1982. They are:

1) to maintain the momentum of the 1970's in arthritis research which has provided some momentous developments in genetics, and to support the undergirding of current research by continuing to train new researchers for careers in arthritis research;

2) to maintain, strengthen and evaluate the existing Multipurpose Arthritis Centers which are looking at new ways to undertake arthritis research, to educate physicians, other health professionals and patients about arthritis, and to provide better care for arthritis sufferers;

3) to initiate a program of epidemiology studies in arthritis which would identify environmental agents and other factors which predispose persons to develop arthritis;

4) to provide special training opportunities for doctors and scientists interested in studying the causes of arthritis in children, and to foster collaborative studies between basic scientists and pediatric rheumatologists; and

5) to expand the support available to the National Institute for Handicapped Research to enable functional disability caused by arthritis to be effectively measured and the various rehabilitative modalities to be assessed. This means that NIHR will need to accord a higher priority to arthritis research than it has to date. As the second leading cause of disability among American workers, it is evident that much cost-effective research can be undertaken in this area.

Until the underlying causes of arthritis are found, fundamental research will continue to be the major instrument with which we probe the elusive mystery of arthritis. At present, basic research accounts for nearly two-thirds of the Arthritis Program budget at the National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD), the lead Institute at the National Institutes of Health (NIH) for studying arthritis. Approximately half of the Musculoskeletal Program at NIAMDD is related to arthritis, as well as part of the Skin program, the three of which constitute the Arthritis, Musculoskeletal and Skin (AMS) "cluster" at the Institute.

Over the past six years, the AMS cluster has been severely curtailed. Its priority scores have averaged 31 points below those of the Digestive Diseases/Nutrition Cluster, and 15 points below those of the Diabetes/Endocrinology/Metabolism Cluster. The Foundation is trying to make NIAMDD aware of the need to make a larger allocation of any additional funds provided the Institute in its FY 1981 and FY 1982 budgets to the AMS research cluster in order that the priority scores for investigator-initiated grants in this cluster may be brought up to the Institute average.

Why is arthritis research important? Because 7 million of the some 31 million persons afflicted with arthritis are disabled. Because Social Security Disability Insurance is paying out over $2 billion a year to workers whose careers were terminated by arthritis and to their families. Because arthritis is costing the nation over $14 billion annually in lost wages, lost taxes, medical care costs, welfare costs, and quackery.

What are we doing about it?

We now know that certain persons are genetically predisposed to contract arthritis. This discovery that in several major forms of arthritis there is a genetic marker, or early warning signal, for detecting a healthy individual's greater susceptibility to developing the disease at some future date than other groups in the population is being rapidly exploited. The two research disciplines of genetics and virology are both involved in this work, since tissue types are determined by patterns of inheritance, and viruses may well be one of several environmental factors that activate or "trigger" an individual's latent predisposition to disease.

It is hoped that these findings will provide a research base for epidemiological research in arthritis. The first international arthritis epidemiology conference since 1966 was convened last fall at NIAMDD. The Foundation encourages the Institute to follow up on the recommendations of this conference and to initiate a major program of epidemiological studies in arthritis at NIAMDD and at the Centers for Disease Control.

During the last several decades, research in systemic lupus erythematosus (SLE), a potentially fatal connective tissue disease which primarily affects women of childbearing age, has enabled us to improve our prognosis from a 50:50 chance of survival four years after diagnosis to a 9:1 chance of survival five years after diagnosis, and an 8:1 chance of living at least 10 years after their disease has been identified. This increased survival is due to a number of factors, including greater awareness of the disease, better diagnosis, and improved drug therapies. However, since an additional 50,000 cases of SLE are diagnosed each year, much more research is needed to pinpoint the underlying cause of this disease and enable us to either prevent it or halt its progressive devastation.

Research is focusing on abnormalities of the immune system, possible relationships between sex hormones, the thymus, and abnormal antibody production, and the testing of Ribavirin, a broad spectrum antiviral agent, which appears to be an effective preventive and therapeutic approach to the disease. Since no toxicity has been observed, the next step may be doing trials of Ribavirin in SLE patients.

The influence of sex hormones is of considerable interest since, at present, no adequate explanation is available for the preponderance of lupus in women (a 6:1 ratio of women vs. men). One research team is currently testing the therapeutic effectiveness of male hormones on mice with lupus since they have found that male hormones suppress and female hormones enhance the disease process.

In the past two years, nine critically ill scleroderma patients have cheated the relentlessly severe hypertension which occurs rapidly after the disease first appears and have avoided this leading cause of death through aggressive anti-hypertensive drug therapy. One newly-developed agent, Captopril, appears to have been dramatically effective, bringing the blood pressure rapidly to normal, improving renal function (another cause of death in scleroderma patients), causing ulcers on the hands to disappear, and even the hardened skin to soften. This limited study is obviously deserving of a cooperative program of research between the Heart Institute and the Arthritis Institute, for research, to date, has been hard pressed to develop a successful therapy for this disease.

Arthritis and cancer researchers are collaborating on a study of regulatory lymphocytes called "T cells" from patients with rheumatoid arthritis and other rheumatic diseases. They have found that patients with rheumatoid arthritis have a defect in the ability to suppress B cells (lymphocytes which participate in immune reactions) activated by the Epstein-Barr virus, a virus associated with infectious mononucleosis and also believed to cause nose and throat cancer in China, and a disease called lymphoma, related to leukemia, in African children. These results, in association with other data on Epstein-Barr virus in rheumatoid arthritis nuclei, suggest that this virus may play a role in the pathogenesis of rheumatoid arthritis.

Artificial joint replacement has been a rapidly developing clinical research area in recent years. Approximately 120,000 hip replacements and 40,000 knee replacements are performed annually. Advancements in other artificial joints are progressing, but at a slower pace. While the short-term success rate is quite high, the long-term prognosis (10 years and beyond) is less certain. The research is now entering a new era with a goal of developing implants that will remain effective for longer periods of time.

The long-term body acceptance of the implant and its wear and corrosion products may be a key to longer successful device implantation. The greatest source of mechanical failure in artificial joints is loosening of the cement attachment between the stem of the device and the surrounding bone. Two avenues of research are being attempted: (1) understanding the mechanism of loosening and improving the cementing technique, and (2) developing a cementless attachment procedure. The latter method allows for bone growth into small pores in the implant surface.

An estimated 6.5 million Americans are victims of rheumatoid arthritis, which in addition to being one of the most disabling forms of arthritis is also systemic, affecting major organs and the circulatory system. Much research attention is being focused on collagenase — an enzyme believed to destroy the protein collagen in cartilage tissue. Corticosteroids, which are used to treat rheumatoid arthritis, appear to inhibit collagenase production, but they can also adversely affect other cellular functions. More selective inhibition of collagenase is therefore needed. Retinoic acid is one agent now being tested in a synovial model system; if these and further tests in experimental models of arthritis prove promising, then clinical trials can be started.

Prostaglandins, long-chain fatty acids, produced by the loose layer of connective tissue (synovial membrane) lining the joint cavity, are believed to modulate the inflammation of rheumatoid arthritis. We now believe that these compounds may also inhibit the formation of new cartilage that could replace that destroyed by protein-degrading enzymes. Further research is needed to define the precise role of postaglandins in the cartilage destruction experienced by rheumatoid arthritis patients.

Several blood purification techniques are being evaluated to test their relevance in reducing rheumatoid joint inflammation. In one technique, called lymphapheresis, the patient's blood is processed in a device called a "continuous-flow cell separator." White blood cells thought to play a major role in the body's immune and inflammatory response (lymphocytes) are removed by this process. Preliminary results of a small number of test patients who were unresponsive to conventional therapies are encouraging. Controlled studies are in progress to establish the precise contribution of lymphapheresis to the clinical improvement observed in this exploratory study.

The most common form of arthritis in children is "juvenile rheumatoid arthritis," which affects an estimated 250,000 youngsters in the United States. Extensive research is now indicating, however, that this disease category includes several distinct clinical entities, which differ according to the extent and severity of joint involvement and the presence of organ dysfunction.

There are already some clues as to what is happening in these forms of arthritis, such as genetic factors that predispose children to develop arthritis, the appearance of auto-antibodies against white cells and against cell nuclei that seem to be different from similar antibodies found in people with the adult forms of arthritis. However, very little research on childhood arthritis is currently being funded. This lack is primarily due to the fact that very few physicians have been trained in pediatric rheumatology (the branch of medicine specializing in the care of children with arthritis) and even fewer have also received the kind of training in basic science research that will enable them to conduct scientific studies on childhood arthritis aimed at uncovering the nature of these diseases.

There is an urgent need for funds to provide research training for pediatricians and basic scientists to devote their attention to juvenile arthritis. In addition, research studies carried out jointly by clinical specialists in childhood arthritis and laboratory scientists need to be supported by NIAMDD. The Arthritis Foundation strongly supports special attention by the National Institutes of Health in supporting high quality research projects in the field of childhood arthritis and the use of funds for research training to train both pediatric rheumatologists and basic scientists in this field.

Osteoarthritis is a leading cause of workers leaving the work force due to disability. Research now shows that osteoarthritic cartilage cells are hyperactive. In addition, scientists have isolated what appears to be a novel secretory protein from calf joint cartilage. Another study has shown that increased levels of dietary Vitamin C reduces the incidence of osteoarthritis.

Researchers are also probing a variety of environmental influences in osteoarthritis, such as, the effects that prolonged, repetitive exercise performed on a nonresilient concrete surface, such as jogging, may have on weight-bearing joints, the primary sites of degeneration in osteoarthritis.

In another study, researchers are exploring the viability of tissue grafts, such as those used in treating osteoarthritis of the knee. In inspecting transplantations of weight-bearing cartilage on bone in animals, they found that two-thirds of the treated joints appeared normal while one-third evidenced degenerative changes apparently related to a lack of an exact match of the allograft, leading to abnormal stresses. These preliminary findings suggest that tissue transplantation may be a promising means of resurfacing joints severely damaged by arthritis.

One area of research of interest to many Members of Congress is that relating to the efficacy of dimethyl sulfoxide (DMSO) with respect to scleroderma. The Cooperative Systematic Studies program, which involves a consortium of 11 arthritis clinics, under the direction of the arthritis center at the University of Utah, is planning to initiate a "double-blind" clinical trial of DMSO this spring, measuring the effect of topical application of a 70% solution of DMSO on the digital ulcers caused by scleroderma. About 100 patients will be involved.

There are, of course, many other exciting things happening in arthritis research. This fact makes it doubly deplorable that there will be a decrease in the arthritis research grants budget of NIAMDD this year and next, according to the way the Administration's FY 1981 and FY 1982 budgets have been allocated within that Institute. The Arthritis Foundation cannot accept this irrational approach to the division of research monies within NIAMDD. Both the Senate and the House Appropriation Committees have called for an equitable allocation of research dollars. There can be no equity when arthritis research grant applicants are denied equal treatment by the Institute with respect to the cut-off point of priority scores at which research grants are funded. When a score of 190 determines the cut-off for quality arthritis research and 215-230 are determined to be cut-off scores for other research grant applicants, there is no equity whatever, nor is the best research being funded.

The Foundation respectfully requests this Committee's good offices be used to urge NIAMDD to return to a policy of equity with respect to the allocation of research grants in order that NIH may continue to be regarded as the fount for quality research.

We also request the restoration of the funds cut from the NIH budgets for FY 1981 and FY 1982 in order that this nation may continue to provide leadership throughout the world in the field of medicine.

The Foundation is also anxious that young M.D.'s continue to be afforded opportunities to opt for a career in academic medicine, rather than join their colleagues in the much more lucrative career of private practice. We are talking about a fast-disappearing and endangered species — the M.D. researcher, who without the Research Career Development Award, the Clinical Investigator Award and the institutional Research Training Grants, may become a historic relic. We desparately need these young M.D.'s in our biomedical research system if we are to continue to probe into the origin of such peculiarly human diseases as rheumatoid arthritis.

Last year NIAMDD supported 98 trainees in arthritis research of whom 82 were M.D.'s. Rheumatology is still a very young field of medicine and will have a justifiable need for national support for some years to come. Many of our medical schools still do not have a full-time rheumatologist on their teaching staff, and more than half lack adequate numbers of trained staff. Without a continuing commitment to this field, we will continue to see tremendous growth in disability caused by arthritis (second only to heart disease), an unnecessary rapid growth in medical care costs caused by misdiagnosis leading to unnecessary hospitalization, by misprescribing of drug therapy — either too little or too much — without adequate surveillance, and by generally underserving the majority of the arthritis patient population which will continue to suffer premature retirement with resultant disability and welfare costs, as well as financial catastrophies in those homes where arthritis leads to disabled wives, mothers and children.

Finally, a word about the Multipurpose Arthritis Centers, of which I am privileged to be a Director. This program, long a goal of the Arthritis Foundation, provides an essential base of operations around which to draw the talents of an amazingly diverse group of health professionals, each of whom has a particular field of knowledge applicable to the arthritis problem. This core of educators, researchers, and health care providers, brought together by the centripetal force of the Arthritis Center grant and sent out to impact upon others in their profession by the centrifugal force of the grant, is central to any initiative where limited resources need to be effectively utilized to serve the largest number of persons possible.

For example, in addition to our important research mission at Ann Arbor, the University of Michigan Arthritis Center is identifying "educational influentials" at community hospitals — physicians who are frequently consulted by their colleagues for advice about difficult cases — and instructing these "influentials" about rheumatology in order that they may act as community resources for other physicians. Preliminary evaluation indicates that this has indeed created a favorable change in treatment patterns of arthritis patients.

The Michigan Center is also teaching arthritis patients "protective techniques" — how to avoid undue stress and thus lessen the deterioration of diseased joints. The possible wider use of this program nationally is being measured by comparing it with a more traditional patient education program at another Michigan hospital.

We are also one of the few Arthritis Centers in the nation doing studies on arthritis in children.

The Arthritis Center concept is vitally important to the education of our medical and patient communities about arthritis, and in assuring that the most recent knowledge about arthritis is rapidly translated into medical practice.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES

ARTHRITIS PROGRAMS BUDGET, FY 1980 - 1982
(Figures in Thousands of Dollars)

	Research Grants	Centers	RCDA's	Research Service Awards	Epi-demio-logy	Comm. Demon. Projs.	Data	Nat'l. Info. Clear-ing-house	Contracts	Total Extra-mural	Intra-mural	Total
FY 1980	21,249	7,111	1,204	1,925	0	0	317	171	181	32,164	5,222	37,386
FY 1981(a)	24,140	7,885	825	1,907	0	0	350	200	1,290	36,967	4,819	41,516
Carter's FY 1981 Rescissions(b)	24,543	7,619	1,278	1,720	0	0	350	200	1,640	37,410	5,835	43,245
Reagan's FY 1981	23,362	7,619	1,328	1,272	0	0	350	200	1,640	35,771	5,813	41,584
Carter's Proposed FY 1982 (c)	28,307	8,335	1,593	1,841	0	0	375	200	1,750	42,451	6,234	48,685
Reagan's FY 1982	23,158	8,882	1,712	1,311	0	0	375	200	1,750	37,388	6,233	43,621
Foundation's Proposed FY 1982	39,825	8,750	1,950	2,300	0	0	375	200	2,000	55,400	6,920	62,320

Notes:

(a) The FY 1981 Institute budget is currently funded under a Continuing Resolution only through June 5, 1981. Fiscal Year 1981 ends September 30, 1981.

(b) President Carter proposed total cuts (rescissions) of $3.232 million for NIAMDD. The effect of this proposed rescission on the arthritis programs budget is shown above. Extramural and intramural research and RCDA's were to have increased as result of effort to equalize the research priority scores within the Institute.

(c) President Carter presented his recommendations for the FY 1982 budget in January, prior to leaving office.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

Regular Research Projects (R01's + P01's)

Priority Scores 1/

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981 Revised Est.
Arthritis	230	206	238	179	221	224	212	196	200	228	197	190
Bone	218	217	212	196	223	229	200	179	190	224	200	190
Skin	237	221	250	190	215	217	208	186	203	212	215	180
A/B/S CLUSTER						223	207	187	198	221	204	187
Diabetes	218	208	208	222	225	264	228	257	245	250	240	230
Endocrinology	228	208	200	171	220	226	185	193	195	230	206	200
Metabolism	218	194	207	168	221	231	200	196	214	231	218	210
D/E/M CLUSTER						240	204	215	218	237	221	213
Digestive Diseases	223	208	237	190	238	275	257	214	208	241	215	215
Nutrition	226	207	223	203	242	273	240	231	242	238	223	200
DD/N CLUSTER						274	249	223	225	240	219	208
Kidney	226	219	258	200	225	220	212	187	194	225	211	200
Hematology	237	211	242	181	225	226	204	194	187	225	197	170
K/H CLUSTER						223	208	191	191	225	204	185
Institute	227	213	232	200	229	239	223	219	223	230	215	200

1/ 90th percentile of number of awards compared to eligible applications.

STATEMENT OF JASON ROBERTS

I am Jason Roberts, Vice President for Government Relations of Juvenile Diabetes Foundation. I am also the father of a 17 year old diabetic son.

The Juvenile Diabetes Foundation is an international voluntary health organization dedicated to supporting and furthering research and education in diabetes. Today, we appear before you on behalf of our Board of Directors and entire membership and their families in over 130 Chapters throughout the United States.

This is my first appearance before a Congressional Committee. I realize that we are meeting some of you today for the first time. You are among distinguished colleagues who have made the appropriations decisions in recent years that have created a new horizon for our children, where we can live each day with a little less fear that our children will become blind, suffer heart disease, or be sustained only by dialysis machines.

Where have we come in just a decade? From a nominal appropriation and Federal commitment to diabetes research in the early 1970s to a coordinated effective program in 1981 that NIH Director, Dr. Donald Fredrickson has characterized as having "advanced knowledge in broad areas of science fundamental to biomedical research in general and to an understanding of other disease processes."

Just five years ago, prevention and cure of diabetes and its complications were mere pipedreams in the minds of parents of diabetic children. Now, diabetes research is being conducted in virtually every NIH Institute. The National Diabetes Advisory Board will soon commence its fourth year in operation. The National Diabetes Data Group and the National Diabetes Information Clearinghouse are operational. There are eight Diabetes Research and Training Centers funded by NIADKDD, which are coordinating research, training physicians, and allied health personnel in diagnosing and treating diabetes, and educating the public regarding diabetes. Twenty states are now developing CDC-sponsored diabetes control projects. The Indian Health Service is implementing five model diabetes care projects. And voluntary health organizations, such as JDF, are raising funds in every state in the Union.

What have these dollars bought? Has your investment produced substantial dividends? The answer is a resounding YES -- in terms of prevention, treatment, and potential cure. The research that this Committee has supported has resulted in breakthrough after breakthrough, making diabetes the showcase of the Federal biomedical research effort.

PREVENTION -- Mr. Chairman, in an article you recently wrote in the WASHINGTON STAR, you stated:

> "Our health care system will fall flat on its face if we do not concentrate on means of preventing sickness and injury...We must focus far more on research that will lead to prevention of disease..."

Our sentiments exactly! With Federal dollars, researchers have demonstrated that several common human viruses are capable of producing diabetes in laboratory animals, thereby possibly leading to the development of a preventive diabetes vaccine. With Federal dollars, scientists have located genetic markers for diabetes which may make it possible to identify some high-risk candidates before they develop diabetes. With Federal dollars, researchers have determined that there is a causal relationship between lack of control (fluctuation in blood sugar levels) and onset of diabetes complications; adequate control may allow us to prevent, or at least mitigate, the devastating and debilitating complications once a person has the disease.

In the area of TREATMENT, Federal dollars have enabled researchers to develop a miniature battery-powered pump, worn externally, which feeds a continuous supply of insulin to the diabetic. With Federal dollars, researchers have produced human insulin through recombinant DNA which may ultimately provide an unlimited supply of cheaper, purer, and more compatible insulin. Federal dollars have allowed researcher and practitioners to develop laser therapy and vitrectomy so that great progress has been made in countering the loss of vision incident to diabetes.

What about a CURE? Our search for a cure -- the desire to tell our children that the insulin syringe and swab are but a thing of the past -- is what binds us together. And we are closer to this goal than we were just two years ago. With Federal dollars, scientists have devised in laboratory animals a way to transplant insulin producing islet cells and overcome rejection by the body's immune system. With Federal dollars, researchers have encapsulated insulin in a reservoir so that it can be implanted and utilized within the body. If these processes work in man, they could provide a natural insulin supply to diabetics -- a cure.

That is the good news. But now follows the bad news. Diabetes remains the third leading cause of death in the United States. It afflicts ten million Americans, claiming 300,000 lives annually -- almost 1,000 lives every day -- and this number is increasing. It is the leading cause of new blindness in this country, and a significant cause of heart disease, arteriosclerosis, stroke, kidney failure, and neurological disorders. It drains the American economy of over $8 billion annually in health costs and lost productivity.

And we are terrified! We read the newspapers and have reviewed the Administration's budget request. We, like you, are taxpayers whose incomes are being drained by inflation. We wholeheartedly agree that waste, fraud, and excessive bureaucracy must be eliminated from Federal programs.

President Reagan has projected a balanced budget for 1985 and he has set forth a four year plan to attain this objective. Our blueprint for diabetes research truly is consistent with this goal. If we continue our momentum -- and through eye, kidney, and viral research and further trials with beta cell transplantation and the implantable insulin pump, prevent these complications -- we will save money many times the research dollar in treatment costs within the next half-decade.

I am not an economist, but I think I understand two premises underlying the cutting of particular Federal programs.

First, cuts should be made in programs which are not cost-effective, which do not generate successes and savings. The Federal biomedical research endeavor is the envy of the globe. We have outlined about the breakthroughs in diabetes alone -- positive results, dividends on this Committee's investment. Are research dollars cost-effective? Let us examine the diabetes research dollar in perspective:

A. Research in diabetes -- the Nation's third leading killer -- represents only about 1/50 of 1% of the Federal budget, indeed only 4% of the NIH budget. If all of the Federal support for biomedical research were eliminated today, it would make only an infinitesimal dent in the Federal budget.

B. The former Comptroller General, Elmer Staats, testified before Congress two weeks ago and identified 15 areas for cuts in the Pentagon budget which would save $4 billion "at an absolute minimum." The entire NIH budget is only $3.6 billion.

C. The Federal government will expend more dollars (about $1 billion) on kidney dialysis treatment in FY 1982 alone than it has devoted to research in diabetes -- a leading cause of kidney failure -- in the history of NIH. Can we sentence our children to dialysis machines so unnecessarily?

D. Diabetes is the leading cause of new blindness. Hundreds of millions of dollars are spent each year by the Social Security Administration (and state and local governments) in payment assistance to the blind and visually disabled. And what is spent by the Federal government each year on diabetes related eye research? Less than $18 million. Can we sentence our children to a life of darkness so unnecessarily?

Second, cuts should be made where the responsibility for attaining a program's objectives can be better assumed by the private sector. Our 130 Chapters aggressively pursue every fundraising endeavor-- from door-to-door solicitation to celebrity tennis tournaments to bike-a-thons. Eighty percent of every dollar we raise goes directly to diabetes research, higher than any other voluntary health organization. Yet, we can in no way, shape, or form, begin to absorb the Federal research burden. Total voluntary health agency support for research is less than 1/25th of NIH's research budget. If the Nation's hundreds of voluntary health agencies were able to double the dollars raised for research, there would not be sufficient funds to simply compensate for the Administration's proposed rescissions in FY 1981 NIH funds.

Mr. Chairman and Members of this Committee, we appreciate the dilemma you are facing as guardians of the public treasury and the public trust. You did receive a mandate in November, but it was not a directive to cut health funding now and pay later manyfold in health costs and physical suffering. You must realize that the wheels of the biomedical research mechanism cannot be stopped one year and cranked up again the next. This Federal research effort is composed of people -- in many instances, brilliant young researchers who are making substantial sacrifices to conduct research.

To rescind FY 1981 funds for research training grants, basic research centers, and clinical trials will literally weak havoc with a research program that has made great strides in combating our Nation's health problems.

To provide for only nominal increases in FY 1982 -- funding levels which will result in cutbacks in research grants, training awards, and contract initiatives -- is to send a resounding message to these researchers that the Federal government's commitment to biomedical research is waning and that nonresearch medical careers should be pursued. This is a reservoir of talent which, once drained, cannot be refilled.

If you, as we pray you will, and Congress, work to appropriate every dollar we have recommended for research, you would barely dent the Federal budget. You would provide an impetus for a cure, and hopefully, prevention of a disease which afflicts 5% of our population. Our detailed appropriations recommendations are appended to this testimony and are consistent with those included in the Third Annual Report of the National Diabetes Advisory Board.

Our recommendations represent minimum appropriations that we believe will enable the National Institutes of Health and other Federal agencies to maintain the momentum that is carrying us towards a cure and prevention of diabetes. They are based on the premise that the cost of research is minimal compared to the cost of disease. The following are several of our key priorities:

National Institute of Arthritis, Diabetes, Kidney and Digestive Diseases

NIADKDD is the cornerstone of the Federal diabetes research and training effort. Under the leadership of the Associate Director for Diabetes, Dr. Lester Salans, this Institute is demonstrating a substantial commitment that recognizes diabetes as the horrendous problem that it is. We are distressed that the Administration has recommended that more than $8 million be rescinded from the FY 1981 continuing resolution, and that the FY 1982 budget request includes only a 2% increase over FY 1981 continuing resolution levels. JDF recommends that no FY 1981 funds be rescinded and that $108.0 million be appropriated to NIADKDD for diabetes research and training in FY 1982. This allocation would enable the Institute:

1. To continue to implement the vital research recommendations of the National Conference on Diabetes regarding: the regulation of carbohydrate and lipid metabolisms; hormone biosynthesis, secretion, and actions; the relationship of obesity and various nutritional factors to diabetes; and islet cell transplantation, to name just a few.

2. To expand NIADKDD's research manpower development programs including Research Career Development Awards, Special Emphasis (Diabetes) Research Career Awards, and New Investigator Research Awards in diabetes.

3. To maintain support for the National Diabetes Data Group, the National Diabetes Information Clearinghouse, and the Diabetes-Endocrinology Research Centers;

4. To augment support for the Institute's kidney research activities, thereby eventually alleviating the fiscal drain of the end-stage renal disease program.

5. To maintain support for Diabetes Research and Training Centers. Researchers associated with DRTCs have conducted research that has led to some of the diabetes breakthroughs noted above, and they have participated in collaborative programs for the Indian Health Service for the training of health personnel in its new model diabetes care program. The Centers are regionally located so that professionals in various areas throughout a region can be trained at these Centers and go back to their practice better equipped to deal with their patient population. The eight Centers currently in existence serve as resources to assist State Health Departments in the development and implementation of CDC-supported diabetes control programs. All in all, DRTCs offer a unique resource for the interaction between traditional biomedical research and health care delivery the result of which has been and will be the expedited transfer of diabetes research "from bench to bedside."

National Heart, Lung, and Blood Institute

The work of the NHLBI is so important to me because I live with the fear that my child will be stricken down by heart disease related to his diabetes in the prime of his life -- just as it struck down your friend and ours, Congressman Bill Steiger. Diabetes is one of the four major risk factors of cardiovascular disease in the United States. The diabetic is twice as prone to coronary heart disease as a non-diabetic, twice as susceptible to stroke, and five times as likely to develop arterial diseases of the limbs.

We believe that no FY 1981 funds should be rescinded and that an appropriations of $21.7 million for the NHLBI's diabetes research initiatives would enable the Institute to conduct the vital research recommended by the National Conference on Diabetes.

National Eye Institute

As discussed above, diabetes is the leading cause of new blindness in the United States; its costs in terms of health dollars, lost productivity, and human pain and suffering is momentous. The National Conference on Diabtes identified several priority areas for ocular research, which can begin to be implemented if Congress appropriates our recommendation of $25.8 million for the diabetes related activites of the National Eye Institute.

Research Manpower Training

Our greatest concern is the need to increase biomedical research training support. As a man whose child has diabetes, I live with the profound fear that today's research advances will not be translated into a cure for lack of qualified investigators to conduct the necessary research. JDF is dedicated to the belief that we must foster a climate in which today's scientists, physicians, and indeed, medical students, will seek out a career in health research. To this JDF itself has supported over 80 fellowships during the past five years.

The problem is aggravated by many factors. Federal funds for support for NIH research have not grown sufficiently in recent years. And now, we are distressed to learn that the Administration has proposed that $62 million in research training funds be rescinded from the FY 1981 budget. This would result in a reduction of almost 500 trainees!! Since 1966, there has been almost a 50% decrease in the total physician-scientist pool in this country and the influx of the young talent into clinical investigation has been severely curtailed. For example, new clinical investigators supported through NIH research training programs have declined from 4,600 in 1971 to 1,800 in 1977. As we noted above, the Federal government is transmitting loud and clear a message which could discourage forever young scientists' interest in pursing a research career.

Accordingly, we heartily endorse the recommendations of the National Diabetes Advisory Board regarding the increase of the number of and the quality of physicians and scientists entering the field of diabetes research. Our recommendations for NIH research, as included in the attached table, include funding for biomedical research training.

Center for Disease Control

Under the capable and innovative leadership of Dr. William Foege, Director, and Dr. William Flynt, the Center for Disease Control has spearheaded a number of very significant accomplishments designed to implement the Long Range Plan to Combat Diabetes.

The Centers have already evaluated and improved local patient education resources, sponsored dieticians, and other members of the diabetes health care team; designed systems to identify and assimilate data on high-risk diabetic population groups; provided surveillance of diabetes health care services; and supported the establishment of two state diabetes registries.

We believe that the CDC's efforts are essential to the improvement of patient care, to reduction of diabetic hospitalization costs, and to adquate screening and diagnosis of diabetes in the population at large. We are now witnessing the establishment of a successful Federal program which is causing a dynamic ripple effect into the states, private agencies, and industry. The payoff for all chronic diseases promises to be great. Accordingly, JDF recommends that the Congress provide $12.9 million in FY 1982 to expand CDC's diabetes control demonstration projects to 25 states.

CONCLUSION

History has been made in this room. Several of you helped create the National Commission on Diabetes, whose Long Range Plan became the foundation of the Federal diabetes effort. This research which you have funded has built upon this foundation. The National Diabetes Advisory Board, through its National Conference on Diabetes, has provided the Congress and the diabetes community with a revised blueprint for research, training, education, and control.

But will the resources be made available so that our children can be cured? We have come a long way -- six major research breakthroughs in less than two years. We want nothing more than to put JDF out of business, and the Federal diabetes research initiative as well. But the bottom line is: Have our children been cured?

Within the next decade, we pray that we at JDF will be able to write the book on how diabetes was cured and the book will be dedicated to you, the Members of this Committee, who had the vision and patience to ignore what might have been politically expedient and to do what you knew in your hearts was right.

Thank you for your attention.

DIABETES APPROPRIATIONS RECOMMENDATIONS
(in millions of dollars)

AGENCY	Proposed FY 1982 JDF Recommendation
National Institutes of Health	
National Institute of Arthritis, Diabetes Kidney and Digestive Diseases	108.0
National Eye Institute	25.8
National Heart, Lung, and Blood Institute	21.7
Division of Research Resources	15.9
National Institute of Child Health and Human Development	12.3
National Institute of Neurological and Communicative Disorders and Stroke	7.2
National Institute of Allergy and Infectious Diseases	4.7
National Institute of General Medical Sciences	1.8
National Institute of Dental Research	2.6
National Institute of Aging	3.5
TOTAL NIH	203.5
Center for Disease Control	12.9
National Institute of Mental Health	3.0
Indian Health Service	2.4
	221.8*

*This total amount was recommended by the National Diabetes Advisory Board and we wholeheartedly support it.

STATEMENT OF DR. BERGEIN F. OVERHOLT

Mr. Chairman, thank you for giving us the opportunity to appear before your Committee to give our views on appropriations in the field of digestive diseases research for the remainder of FY 1981 and for FY 1982.

My name is Bergein F. Overholt, M.D. I am a practicing gastroenterologist in Knoxville, Tennessee, having begun my practice in 1969. As a result of this practice experience I feel that I have excellent knowledge of the needs of patients with gastrointestinal diseases. Today I represent the American Society for Gastrointestinal Endoscopy (ASGE) which has a serious concern for those patients. This Society represents over 2,500 physician and surgeon members who have acquired training and skills in the proper use of flexible fiberoptic endoscopes to visualize safely areas of the digestive tract previously seen only with surgical intervention.

While our Society is primarily concerned with quality care and education of its members, it has a deep interest in research in the entire field of digestive diseases, and in particular in endoscopy. That is why we have come to testify regarding NIH funding and, in particular, funding for the Institute which provides most of the research opportunities for the field.

The enormity of the problem of digestive diseases has been well established by the congressionally-created National Commission on Digestive Diseases: 10% of the total cost of medical illness, 15% of general hospital admissions, and nearly 200,000 deaths for a total economic loss - including time lost from work - of $35 billion a year. Many of us in this room have been afflicted by one or more digestive diseases, either mild or severe, and can attest to the associated misery and discomfort. You can easily imagine the time lost and the expenses incurred with a chronic disorder of this type such as gallstones, ulcers, colitis or Crohn's Disease, cirrhosis, cancer, and the like.

The ASGE feels the logical solution to alleviate much of the suffering and expense associated with these diseases lies in the development and funding of research, training and clinical programs that promote early diagnosis and effective management of digestive diseases.

First, Mr. Chairman, we would stress that our young researchers are our most important long-term asset. We urge this Committee to continue stability of funding for research training. It is difficult enough to keep young people in the research field, given the difficulties many of them face paying off loans for their medical school education, but it would become more difficult still if they sensed, and reacted to, a pattern of unstable funding of research training. Those who are young and new to our field find stability of training funding to be vital to their future planning. All of us applaud the new Administration's attempt to introduce stability into our national economic life, and somehow must recognize the young research trainee's need as well for the same stability.

Second, Mr. Chairman, all of us in this room know of the explosion of new knowledge in the last decade in biomedical research. This explosion of knowledge has affected endoscopy as it has other areas. But the promise of the near-term future is even greater than in the recent past. We urge you to consider that the NIH, almost alone among the Fderal health agencies, has an unbroken history of excellence, and relationships with its clientele groups which is excellent. We urge that the opportunities are so great and promising, that this Institute be funded at a level of approximately $410,000,000. My own recent personal experience, and study, indicate to me that the research clusters in this Institute are all in this explosive mode regarding new knowledge, and the opportunities would certainly indicate that that level of funding would be useful. We understand that the Coalition for Health Funding supports this level as well.

Now let me speak of two small programs, which could prove of considerable value in the future, which have just been established by law. The first is the National Digestive Diseases Advisory Board. This Board, similar in concept and constitution to two previously established boards in the NIAMDD (the Diabetes Advisory Board and the Arthritis Advisory Board), would serve as the advisory and coordinating board for digestive disease and allied research across the NIH. They would be required to indicate to the Congress and the Secretary of Health and Human Services what research programs should be undertaken in the field. The diabetes and arthritis boards already have proved their usefulness, and we believe this digestive diseases board would do so as well.

Also, at the end of last year when the Congress created the advisory board, it also created within the Institute the National Digestive Diseases Education and Information Clearinghouse. We are hopeful that this clearinghouse can also live up to its promise--we all know that any instrument which can inform patients, physicians, and other laypersons on the digestive diseases, opportunities for care, and the research being done on them, would be valuable. That clearinghouse has considerable support from many of the professional and lay groups in the field, and we add our support. We hope that for both these programs that this Committee will place supportive language in its bill report, which will cause the Institute to move forward to implement them.

Mr. Chairman, let me now deal directly with gastrointestinal endoscopy. This technique refers to the use of flexible instruments called "scopes" that incorporate hair-like glass fibers to transmit excellent visual images even around the bends and curves of the digestive tract. Recent advances, which I might add were developed in great part thanks to Federal support and encouragement, now allow safe, rapid, and relatively comfortable examinations of the esophagus, stomach, duodenum and the entire colon. In addition, probes passed through these instruments can be placed into the ducts of the liver and pancreas to allow injection of radio-contrast materials for x-ray studies.

Likewise, other probes can be passed through these "scopes" to take biopsy and cytology specimens, remove foreign bodies and even remove polyps and other growths from the intestine.

A classic example of the benefits of the advances in gastrointestinal endoscopy is shown in the diagnosis, management, and prevention of colon cancer. Over 100,000 new cases and 40,000 deaths from this cancer are reported yearly. Thanks to endoscopy, physicians are now diagnosing the condition earlier and thus provide the patient with improved survival potential. And now since polyps, which are considered by most authorities to have a malignant potential, can and are being removed through these instruments, I believe that it is just a matter of time before we see a reduction in the mortality from cancer of the colon.

Of considerable importance is the funding through NIADDKD of studies in upper gastrointestinal bleeding. This is a common and serious medical problem in the United States with approximately 250,000 new hospital admissions occurring yearly as a consequence of these bleeding episodes. Gastrointestinal endoscopy now allows viewing of the upper portion of the GI tract and improves the diagnostic results in this condition. Unfortunately, however, the nearly 10% mortality rate for upper GI bleeding has not decreased substantially in recent years. The subject of upper GI bleeding was addressed at an NIH Consensus Development Conference in August, 1980 with discussions of endoscopy and other alternatives in this disease. The use of endoscopy in upper GI bleeding was presented in detail to a 10 member panel of experts who made recommendations to assist practicing clinicians handling this disorder. The panel predicted that the diagnostic information obtained by endoscopy will stimulate the development of newer therapies for treatment of the different causes of upper GI bleeding. Along these lines, additional NIADDKD grants are directed towards studying the control of upper GI bleeding by endoscopic techniques including laser coagulation, electrocoagulation, heat probes, suture clips and tissue glues.

Other areas of investigation in digestive diseases supported by NIADDKD utilize endoscopic research as an important and often essential technique in the basic and clinical investigation of gallstones, Crohn's Disease, ulcer disease, and the various forms of liver disease.

In closing, the American Society for Gastrointestinal Endoscopy strongly urges your support for: (1) funding of NIADDKD; (2) funding programs in training, research, and clinical studies in gastroenterology and gastrointestinal endoscopy, as well as (3) the Clearinghouse on Digestive Diseases, and (4) the National Advisory Board on Digestive Diseases.

Our Society is very aware and sensitive to the needs to reduce Federal expenditures. We are asking only that a fair share be designated toward programs in gastroenterology and gastrointestinal endoscopy. Certainly in your deliberations you will need to set priorities in funding. In medical illness, priorities should be directed toward diseases that have the greatest economic impact and the greatest potential for alleviation. Digestive diseases fits these two priority areas and deserves your support.

On behalf of the American Society for Gastrointestinal Endoscopy I wish to thank you for your time and consideration.

STATEMENT OF GAIL E. RIGGS

As an arthritis patient for 35 years and as a health care provider, working as the Associate Director of an arthritis "team," I believe that I can bring two distinct perspectives to an overview of the recently formed national network of Multipurpose Arthritis Centers. The Arthritis Centers, of which there are 21, need to be viewed more as newly formed organizational entities than as some kind of architectural reshaping of a teaching hospital at which most of these Centers are housed. It is a bringing together of the arthritis team -- the rheumatologist, orthopaedic surgeon, physiatrist, nurse, physical and occupational therapists, social worker, patient advocate and others, each of whom have individual skills necessary to meet the complex needs of each arthritis patient. Judged on their capacity to perform high quality biomedical research and to train health professionals, the Arthritis Centers are also developing new ways of making more effective use of what we already know. Thus, one of the most important missions of the Centers is to encourage better medical care for people with arthritis.

Since 70 percent of physicians have never been exposed to formal training in arthritis, the Centers are developing new educational tools, which together with the Arthritis Foundation's slide collection, will provide a more effective education for medical students and physicians to enable them to do a better job in taking care of people with arthritis.

Centers are also developing new teaching programs and materials for instructing nurses, physical therapists, occupational therapists, counselors and other allied health professionals. Since little is taught about arthritis in Schools of Nursing or Allied Health, Arthritis Centers have become a major training ground for these professionals.

Other educational programs being developed by Centers are aimed at physicians in family practice who are not arthritis specialists and at arthritis patient clubs.

The new knowledge about arthritis that is being developed by these Centers is being made available to patients and physicians throughout the United States. In addition, special needs are being met by the Centers such as researching methods to teach Social Security examiners more about the impact of arthritis on various jobs and about how people with arthritis can be trained to work again which can then be utilized in every State.

The Arthritis Health Professions Association of the Arthritis Foundation began as a national organization in 1965 with 40 members, and, with a helping hand from the Rehabilitation Services Administration which provided the Foundation with a three-year grant to enable our fledgling group to become better known, with our involvement in the 33-state Regional Medical Program in arthritis in 1974-76, and with the help of the Multipurpose Arthritis Centers, authorized by the National Arthritis Act of 1974, we have grown to 1,400 members.

The Arthritis Centers have also seeded the development of 31 local AHP Sections at Arthritis Foundation chapters in 26 states. Nine more sections are nearly organized. Local sections average 20 to 40 members. Our national organization is represented by all states except three, Montana, South Dakota, and Wyoming. We are deeply indebted to the federal government for helping us in our development and dynamic growth.

Arthritis health professionals are a primary source of skilled medical care and rehabilitation resources for arthritis patients. In fact, they may be in the best position for teaching and helping the patient with his or her rehabilitation. I'm in the unique position both as a provider and consumer to know this.

A major thrust of the Multipurpose Arthritis Centers is to provide education for the patient. Arthritis health professionals teach patients individually or in classes about the various aspects of their disease and how to cope with the painful and crippling effects of it. As an arthritis patient of 35 years, I would have considered myself indeed fortunate to have received years ago when my arthritis was at its worse the kind of education we now offer patients in our Centers.

Without Multipurpose Arthritis Centers, allied health professionals would find it much more difficult to learn about the distinctive needs of arthritis patients.

Without Multipurpose Arthritis Centers, allied health professionals would not be trained as patient educators and thus be in a position to help and educate many thousands of patients.

Without Multipurpose Arthritis Centers, thousands of patients would remain ignorant of their disease and uninstructed as to how they can cope with this chronic, debilitating and progressively disabling disease which leaves so many patients homebound with a life void of social contacts.

These Centers represent a unique resource with great potential for providing the major advances in research and the development of new and more effective techniques for bringing these advances to the benefit of the many millions of Americans with arthritis. The Arthritis Foundation recommends that an additional $1.5 million be made available to the Multipurpose Arthritis Centers in FY 1982 in order that this program may continue to offer its special form of support to the arthritis community.

Crippling rheumatoid arthritis and many other forms of arthritis hit people during their most productive period of life. The economic cost in lost work days and disability is surpassed only by heart disease. In an era of productivity it is not cost-effective to under-budget a disease which affects approximately 250,000 children and 6 million young adults. Nor can we afford to ignore the need to assure a better quality of life and a better chance for independent living for the 25 million older Americans who are also afflicted with arthritis.

We are just beginning, but we now have the organizational structure through the Multipurpose Arthritis Centers, and working in conjunction with the Arthritis Foundation, to impact significantly on the lives of over 31 million people with arthritis. We look to this Committee to help maintain the momentum we have achieved. Although some States have begun to support some arthritis programs, the public continues to look to the federal government for support of biomedical research and for translation of this research into productive lives for those whose futures depend on the answers this research provides.

Beginning in the mid-1970's, allied health professionals have been sharpening their research skills with the help of research grants from the Arthritis Foundation in order to become full-fledged members of the arthritis "team" that wears three hats: researcher, teacher, health care provider. Our teaching skills have been improving since the early 1970's when the Foundation started awarding post-graduate Fellowships to AHP's. Last year, five Fellowships and eight research grants were made to AHP's in arthritis. This year, 1981, there will be eight Fellowships awarded and two research grants.

When Congress renewed the authority of the National Arthritis Act last year (PL 96-538), they added authority for the Multipurpose Arthritis Center grants to include AHP Research Fellowships. We are grateful for this intelligent appraisal of our needs, and we hope that future Arthritis Center grants will recognize the need to prepare more AHP's for research careers.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES

ARTHRITIS PROGRAMS BUDGET, FY 1980 - 1982

(Figures in Thousands of Dollars)

	Research Grants	Centers	RCDA's	Research Service Awards	Epi-demiology	Comm. Demon. Projs.	Data	Nat'l. Info. Clear-inghouse	Contracts	Total Extra-mural	Intra-mural	Total
FY 1980	21,249	7,111	1,204	1,925	0	0	317	171	181	32,164	5,222	37,386
FY 1981(a)	24,140	7,885	825	1,907	0	0	350	200	1,290	36,967	4,819	41,516
Carter's FY 1981 Rescissions(b)	24,543	7,619	1,278	1,720	0	0	350	200	1,640	37,410	5,835	43,245
Reagan's FY 1981	23,362	7,619	1,328	1,272	0	0	350	200	1,640	35,771	5,813	41,584
Carter's Proposed FY 1982 (c)	28,307	8,335	1,593	1,841	0	0	375	200	1,750	42,451	6,234	48,685
Reagan's FY 1982	23,158	8,882	1,712	1,311	0	0	375	200	1,750	37,388	6,233	43,621
Foundation's Proposed FY 1982	39,825	8,750	1,950	2,300	0	0	375	200	2,000	55,400	6,920	62,320

Notes:

(a) The FY 1981 Institute budget is currently funded under a Continuing Resolution only through June 5, 1981. Fiscal Year 1981 ends September 30, 1981.

(b) President Carter proposed total cuts (rescissions) of $3.232 million for NIAMDD. The effect of this proposed rescission on the arthritis programs budget is shown above. Extramural and intramural research and RCDA's were to have increased as result of effort to equalize the research priority scores within the Institute.

(c) President Carter presented his recommendations for the FY 1982 budget in January, prior to leaving office.

Statement of Dr. Richard M. Freeman

Thank you for allowing us this opportunity to express our support for the program of the National Institutes of Arthritis, Diabetes, and Digestive and Kidney Diseases. We are particularly pleased that "kidney" has been added to the name of the Institute and thank you sincerely for your action. My name is Richard M. Freeman, Professor of Medicine at the University of Iowa College of Medicine, and President of the National Kidney Foundation. I speak on behalf of the lay and professional volunteer membership of this organization, which is the leading voluntary health organization dedicated to the needs of patients with kidney and urologic diseases.

I also speak for the Intersociety Committee for Kidney Research, which is composed of organizations whose membership is dedicated to finding answers to the problems of patients with kidney and urologic diseases. The Intersociety Committee is composed of the following member organizations: The American Society of Transplant Surgeons, the American Urological Association, the American Society of Nephrology, the Council on the Kidney of the American Heart Association, the American Society of Artificial Internal Organs, the American Society of Pediatric Nephrology, the Renal Physicians Association and the National Kidney Foundation.

Before dealing with research needs, I would like to make a few comments about the end stage renal disease program, because as Americans, we have perhaps not taken enough pride in its success. We have not thanked Congress adequately for its passage of Public Law 92-603. To put things in perspective, I would like to compare the dialysis scene in 1967 to that of 1980. In 1967, approximately 7% of patients receiving hemodialysis in the United States were black; now that figure is closer to 25%. In 1967, 25% of patients receiving hemodialysis were women; now that figure is approximately 50%. In 1967, approximately 7% of patients receiving hemodialysis were over the age of 55 years; that figure is now close to 50%. In short, racial minorities, women and the elderly are now receiving dialysis treatment without discrimination, which they would not have received ten years ago because of lack of funds. Americans have the right to be proud of that accomplishment! This is especially so since, according to the recent figures of the Health Care Financing Administration, the cost of dialysis per capita is actually slightly less for the last reporting year than it was for the preceding year.

The care of patients with end stage renal disease, however, is costly. Efforts to eliminate these costs will occur only if successful research programs are generated and sustained. Those of us familiar with the academic community are particularly distressed by the lack of young investigators entering the field of adult and pediatric nephrology and urology. In a recent survey of medical schools undertaken by the Scientific Advisory Board of the National Kidney Foundation, it was determined that there are over 130 vacancies in these three fields; it is anticipated that by 1984, the projected vacancies will reach 483! Potentially successful investigators are leaving academic medicine often because the grants which would have supported their investigative efforts were "approved but not funded." You have no idea how discouraging those four words are to the aspiring scientist.

It is the irrefutable fact that many grants of high merit are not funded these days. In fiscal year 1980, only 38% of approved grants in the kidney- and urology-related area was funded. In fact, less than 40% of approved grants has been funded in four of the last five years. This year, funded grants will be at an even lower level. Under these difficult circumstances, the young investigator especially suffers, since the well-established scientist is more likely to be supported. In ten years, where will our new ideas come from?

If you should ask us how research funds should be distributed, we remain committed to the following priorities for NIH support of medical research:

1. Individual-investigator-initiated research project grants.
2. Research training, including both institutional training programs and individual research fellowship grant awards.
3. Program project grants.
4. Specialized centers of research.

Which specific diseases or fields deserve priority? We believe the most productive approach is to support the research that is judged to be the most meritorious and most promising by the scientists on the panels of the peer-review system who examine research proposals. We further believe that in distributing research grant funds among Divisions of the Institute, efforts should be made to assure that research supported by each Division is of equal quality.

From the standpoint of research needs in nephrology and urology, the hearing on this subject before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, House of Representatives (June 29, 1978, serial number 95-136) still contains much relevant material. Recommendations and priorities for study as compiled by 95 national experts were made in the following areas:

1. Glomerulonephritis and other immunological renal diseases.
2. Renal failure (including dialysis and transplantation).
3. Circulatory and hematologic disorders (including hypertension).
4. Urinary tract infections and obstructive disorders (including kidney stones and diseases of the prostate).
5. Pediatric nephrology and urology.
6. Normal structure and function.

We wish further to emphasize the crucial importance of federally supported clinical research centers on clinical investigation. We estimate that 70 to 80 percent of clinical investigation in nephrology is performed in relationship to clinical research centers throughout the United States. Clinical research center support allows the investigation of new and unanticipated patient problems in a way that would be distinctly difficult or impossible to obtain by usual granting methods.

I would, finally, like to quote from a letter directed to the President of the United States by a dialysis patient from New Jersey. In the four-and-one-half-page letter, this patient carefully outlined the daily problems of the end stage renal disease patient to the newly-elected President. He ended the letter with the following quote:

"I beg you to funnel ample funds into research to find a cure for future patients. Whether the answer lies in surgery or medicine, I know not which, but there is an answer. This answer will relieve the federal government from substantial funding and, President-elect Reagan, you will have helped many people's prayers."

Please help us help this and other patients.

STATEMENT OF DR. JOHN H. SADLER

The Renal Physicians Association endorses the statement of the Intersociety Committeefor Kidney Research presented by the Kidney Foundation. The Renal Physicians Association represents practicing physicians who care for patients with kidney disease, including end stage renal disease(ESRD). Only a minority of our members are directly involved in research to be candidates for NIH grant funds. All our members recognize that kidney research is necessary if we are to reduce the need for expensive maintenance of people without kidney function.

The federal government spent 1.3 billion dollars on some 50,000 patients with ESRD last year. Nearly 90% of those people survived and the quality of life was good for most of them. The country can take pride in this great accomplishment. At the same time, less than 50 million dollars was spent through the NIH studying kidney disorders. More than 40,000 patients received more than 6 million dialysis treatments last year. Though the aggregate cost was large, the cost per treatment has not changed materially in eight years. Cost containment is clearly at work; but it is not enough.

A major saving can only occur by reducing the number of patients in need. We lack the knowledge to do that. Research is the path to that vital knowledge.

As research costs increase, failure to increase budgets accordingly will reduce research. Were this a bloated, uncritical, unproductive research establishment, it would not merit continued funding. that is not the case. The mechanisms through which grant applications go at the NIH is stringent, competitive, and appropriate. Now only a minority of approved high quality grants are funded. Funds for training young investigators have almost disappeared. The combination of strictures prunes not the existing research establishment, which is already lean and cautious, but the new growth on which future knowledge depends. Today's teachers and investigators did their early work with the assistance of the NIH. There is no other broad resource for training investigators and supporting new ideas. The pipeline is long; those who turn away today will leave a research gap not felt for four to ten years. once detected, that gap cannot be filled quickly.

The economy demands critical judgements. The budget which does not plan for essential future growth of knowledge may compromise that future and change its course irretrievably. It would be wrong to barter the future of medical investigation for a balanced budget.

STATEMENT OF ELIZABETH SHIELDS ASTOLFI

I am Mrs. Betsy Astolfi of Reston, Virginia. My four-year-old daughter, Katherine, has the brittle bone disease, osteogenesis imperfecta (OI). I am pleased to have this opportunity to appear before this subcommittee as a representative of the American Brittle Bone Society (ABBS) -- a national, voluntary, health organization dedicated to the support and furtherance of research and education relating to the brittle bone diseases, particularly OI and osteoporosis.

In each of the past three years, this subcommittee has taken important and long-needed action to enable the establishment (or, at least, the first steps toward the establishment) of an effective research base aimed at finding the underlying causes of OI and other bone diseases. By providing increased appropriations for the musculoskeletal diseases program of the NIADDKD, and by commenting on the importance of bone disease research, this subcommittee has had a tremendously beneficial impact on an area of biomedical research which is not only vital to the health and well-being of millions of Americans but which is also particularly ripe for major scientific advances.

The progress which has taken place during these three short years is still fragile, however. It is essential for continued progress (and and for the hope which progress-to-date has fostered) that there not be a sudden retreat from the federal government's commitment in this area.

Let me focus on OI -- the brittle bone disease which my daughter has -- to illustrate what I mean.

A few years ago, of all the billions of dollars expended for support of biomedical research through the extra- and intramural programs of the

NIH, there was virtually nothing (neither money, nor time, nor even words of encouragement) spent on research specifically directed toward OI. Only at the most basic levels of research was anything being done which could be said to bear even a remote potential relationship to the root problems of OI.

During the past few years, however, while the Congress has acted as a catalyst by providing funds and expressing support, two parallel .evelopments have occurred, bringing about rapid and dramatic change: for one thing, the OI population has become much more active and better organized than before, making it more feasible now for potential researchers to locate and enlist the cooperation of OI families in research studies; and, at the same time, new biomedical research technologies such as cloning and splicing of genes have recently become increasingly available, opening up avenues of study with more direct, practical, and immediate relevance to OI.

As a result of these developments, significant progress has been made. 'oday, there are more than fifteen top researchers in this country studying OI. Extramurally, the NIH -- particularly the NIADDKD -- has done a marvelous job and played a key role, not only by providing the financial support needed for most of these researchers to carry out their studies but also by working to stimulate additional research interest and foster the productive interchange of ideas through workshops and seminars. Moreover, a multi-faceted intramural program to study OI has been established within the Clinical Center at NIH. Altogether, several hundred thousand dollars of federal funds committed to OI research for studies extending over a period of a few years has changed the situation from a stagnant and hopeless one, to one in which there is now, for the first time, a great deal of hope.

It would be a mistake, however, to view this newly hopeful situation for OI as one which no longer needs federal support. Research , in order to remain viable, needs stable financial support -- not just the existence of important and interesting scientific problems to tackle. There is ıo "fat" in the federal government's level of support for OI research. Because of substantial "payline" differences among the various program areas of the NIH, with bone disease research proposals being subject to extraordinarily stringent "payline" limitations, it is only the very top quality research proposals which have received funding in the field of OI. Any cutback in the level of funding at this point could simply and effectively crush the work that has been started toward finding a cure for OI and drive the researchers back to more well-heeled areas of endeavor. In fact, there is great need and much room at present for strengthening the federal commitment in this area.

Because this subcommittee has heard testimony on several occasions during the past three years from Roberta DeVito of the ABBS, and from Dr. G. Donald Whedon of the NIH describing OI, its impact, and its wealth of research opportunities, I will not go into detail on these matters now. But I would like to remind you for just a moment, Mr. Chairman and members of the subcommittee, of some of the main features of what it can mean to have OI:

1. A lifetime of broken bones -- in some cases more than 200 fractures, some of them occurring before birth.
2. Life-threatening deformities and fragility of the spine, chest, and skull.
3. Disabling deformities of the arms and legs.
4. Deafness and vertigo related to abnormal bones in the ear.
5. Shortness of stature -- many adults being less than three feet tall.
5. Recurrent pneumonias.
6. Easily broken teeth.

Let me hasten to remind you also that the thousands of children and adults who have OI are bright, intelligent, positive-thinking people who, in the midst of extremely difficult physical circumstances, go about their lives and their work with an enthusiasm and a fortitude that can serve as an inspiration to all of us. They give much more than they receive, and could make an enormous contribution to their fellow human beings if only the existing physical problems they face could be solved.

Although the brittle bone diseases as a group affect very large numbers of people (osteoporosis being the best known and most prevalent of them, estimated to affect at least 15 million people in the United States), there are many other diseases that have had a great deal more attention paid to them over the years by the public, the Congress, and the NIH. Also, this subcommittee has to deal, of course, with many other federal responsibilities beyond just those involving biomedical research. In this time of possibly drastic budget-cutting, it requires much wisdom and courage to find where the "fat" is on the one hand,

and on the other where are the essentials that cannot be cut without doing irreparable damage to the health of the nation.

As you make your decisions regarding Labor, Health, and Human Services appropriations, I respectfully submit to you that there is nothing with greater positive potential impact in human terms if it receives adequate funding, nothing with more potentially severe negative impact if it does not, and nothing containing less "fat," than the federal government's commitment to research on OI and other brittle bone diseases.

Please do what you can to strengthen and build upon the progress that is being made.

Thank you.

STATEMENT OF SUZANNE ROSENTHAL

Good morning gentlemen,

I am Suzanne Rosenthal, Chairman of a newly created Coalition of Digestive Disease Organizations, which represents 15 lay and medical voluntary organizations with primary interest in digestive disease health care, research and education.

Why a Coalition and why are we here today?

Digestive Disease as a term and as a single entity defies an easy understanding of what in fact it is and what impact it has on our nation's health and economy. The nation's awareness of digestive disease has, until recently, been either non-existent or minimal (except by the 20 million chronically ill digestive disease patients or the 14 million persons who suffer acute episodes of a digestive disease illness each year). Lay voluntary agencies servicing the digestive disease patient and public population are in their infancy and have extremely limited funds available to publicize their existence and the urgent health needs towards which they address their efforts. With no single organization able to meet the needs of the patients or the physicians concerned with the many different digestive diseases, it was reasonable to expect that an overall Coalition would be created to help to identify and serve the common needs and interests shared by all of the organizations and their constituents.

EXPECTATIONS OF NATIONAL COMMISSION ON DIGESTIVE DISEASES

Fortunately, four years ago Congress established The National Commission on Digestive Diseases to accomplish three major tasks, which incidentally have led to the basis and focus of the Coalition:

1. Study the medical, social and economic problems attributable to digestive diseases.
2. Evaluate the present use of resources to control the problems identified, and...
3. Develop a long-range national plan for the organization and effective use of national resources to deal with digestive diseases.

The Commission, funded at close to $1.5 Million, functioned for almost two years, including the time to prepare the Report to the Congress. The Report presented the findings of the Commission and the national long-range plan to combat digestive diseases, which incorporates the most promising leads in research and needed new directions and health care delivery and education. It was suggested that if all components of the plan were implemented without delay, the expectation of benefits to the public would be evident and measurable in varying stages in one to ten or more years. A Summary of the Report is attached to this testimony to refresh the memory of those Senators who were on this Committee at that time, and for those Senators perhaps as yet unfamiliar with the Commission Report.

PROGRESS SINCE COMMISSION REPORT

It is now two years since the Commission Report to Congress was made public and a woeful lack of any significant movement is clearly evident. Perhaps the most singular event is the recent creation of the Coalition of Digestive Disease Organizations, designed to promote the recommendations of the Commission.

What in fact has occurred to have made that 1.5 million dollar investment in the Commission "pay off"? You can determine if it was a worthwhile investment:

1. Legislation authorizing a National Digestive Disease Advisory Board was passed, but remains unfunded and therefore not established.
2. Even barely adequate appropriation levels for digestive disease research training and research programs for FY 1981 and FY 1982 are in serious jeopardy if administration proposals are to be adhered to.
3. Legislation authorizing a National Digestive Disease Education and Information Clearinghouse was passed, but is severely underfunded with the minimal funds allocated to it taken from important and already underfunded research programs at the NIADDKD.

IMPACT OF DIGESTIVE DISEASE

Considering the scope of digestive diseases which includes more than 50 disorders and diseases of the esophagus, stomach, intestines, gall bladder, liver and pancreas; considering the cost to the nation of $17 Billion in direct health care costs and $35 Billion in total annual economic loss resulting from digestive disease - the primary reason for major surgery and the leading cause of hospitalization in the nation - we, those of us here today representing the digestive disease sufferers and the health care providers through the Coalition of Digestive Disease Organizations, feel frustration and outrage, for so little has been done to even begin to meet the Recommendations of the Commission.

NATIONAL DIGESTIVE DISEASE ADVISORY BOARD

In order to organize and coordinate any short or long-term national plan to combat digestive disease, it is essential that the National Digestive Disease Advisory Board be established and adequately funded so that it, like the National Diabetes Advisory Board and the National Arthritis Advisory Board created before it and proven successful in their fields, can provide valuable contributions to the improvement of federal digestive disease programs and facilitate coordination with other governmental and non-governmental activities.

The Senate-House Conferees in the report language to the "Health Programs Extension Act of 1980" expressed their concern and expectation that the Digestive Disease Advisory Board "continue the high performance standards set by the National Diabetes Advisory Board and the National Arthritis Advisory Board." Unfunded, of course, we cannot even begin to make the attempt to attain that goal. Specific funds for the establishment and functioning of the Advisory Board must be appropriated.

PROGRESS IN DIGESTIVE DISEASE RESEARCH

Regarding digestive disease research training and research support, the Coalition of Digestive Disease Organizations has many very serious concerns. First, however, let me share with you just two of the successes in the digestive disease health care of patients with peptic ulcer and hepatitis achieved through a partnership of federal funds and the private sector through non-profit agencies and/or pharmaceutical companies. Let it be understood that we do not come hat-in-hand asking for more federal funding without our own strong commitment to do even more than our share this year and in years to come.

ULCER DISEASE

The severity of ulcer disease has been significantly reduced due to the improvement of drug therapy through the use of cimetidine. Further research in gastrointestinal bleeding through the use of endoscopy and laser healing are areas in which we are hopeful in terms of treatment of digestive disease.

LIVER DISEASE

The Hepatitis-B Vaccine that has been so elusive has been discovered and will finally be mass-produced in 1982. What is its impact? It is estimated that there will be 350,000 cases of Hepatitis-B this year. 5-10% of whom will become chronic carriers. There are an estimated 700,000 carriers of Hepatitis-B in the U.S. today who have the potential to infect others through such simple acts as kissing or other intimate contact. 30% of the carriers are at risk of developing chronic active hepatitis, cirrhosis and cancer of the liver. Today there is no cure or prevention. Tomorrow there will be one. Only through intensive research with the combined efforts of all sectors of the nation was this "miracle" accomplished.

PEDIATRIC LIVER DISEASE

Liver diseases are the fourth leading cause of death. One of our areas of deep concern involves a group of diseases which afflict thousands of children with liver disease, adding remarkably to those mortality figures. Pediatric liver disease has for too long been relatively ignored as an urgent area of research concern as evidenced by a minimal number of pediatric liver research projects presently being funded by the NIH. Biliary atresia, neonatal hepatitis, galactosemia and Wilson's Disease are amongst those conditions that affect thousands of youngsters. Liver disease is erroneously associated with alcohol and drug abuse, and in the child it is frequently misdiagnosed or diagnosed too late to prevent irreparable damage to the liver. Liver transplantation provides the only hope for many terminally ill children. Without adequate funding for this procedure they will die. New techniques and anti-rejection therapy herald a new era in liver transplantation with a dramatic increase in survival rates. This is an area which should be monitored and supported in terms of research funding and catastrophic costs for patient care.

INFLAMMATORY BOWEL DISEASE

Inflammatory Bowel Disease - Crohn's disease and ulcerative colitis - which affect upwards of 2½ million people is found most frequently in the young. Hundreds of thousands of youngsters before puberty are doomed to a lifetime of suffering too often resulting in permanent growth retardation due to intestinal deterioration and effects of drug therapy. A recent joint effort of the NIH and the National Foundation for Ileitis and Colitis resulted in a highly successful international Conference on Growth Retardation in Inflammatory Bowel Disease. We are hopeful that the results of this unique scientific workshop will lead to the prevention of such severe effects of Inflammatory Bowel Disease. Will a severely reduced NIADDKD budget limit the important future research activities that will be planned based on this workshop - or will it all have been for naught?

DIET AND NUTRITION

Nutritional concerns of our adult population is evidenced by thousands of books and articles and have achieved mass media attention. But dietary factors in causing pediatric digestive disease such as Celiac disease have been largely ignored, as have the nutritional imbalances produced by many different digestive diseases. Research funds focused here could have significance both for children and for adults whose diseases or nutritional imbalances start in childhood.

RESEARCH AND RESEARCH TRAINING

This is not the time to slow down the research initiatives and investment in research training. Dire and permanent consequences could result. It has been estimated that due to an earlier administration's impounding of research funds, hundreds of research trainees left research disillusioned by the American Dream that our nation would defend and protect above all the health of its people. Research today is our only hope for a healthy tomorrow.

NATIONAL DIGESTIVE DISEASE CLEARINGHOUSE

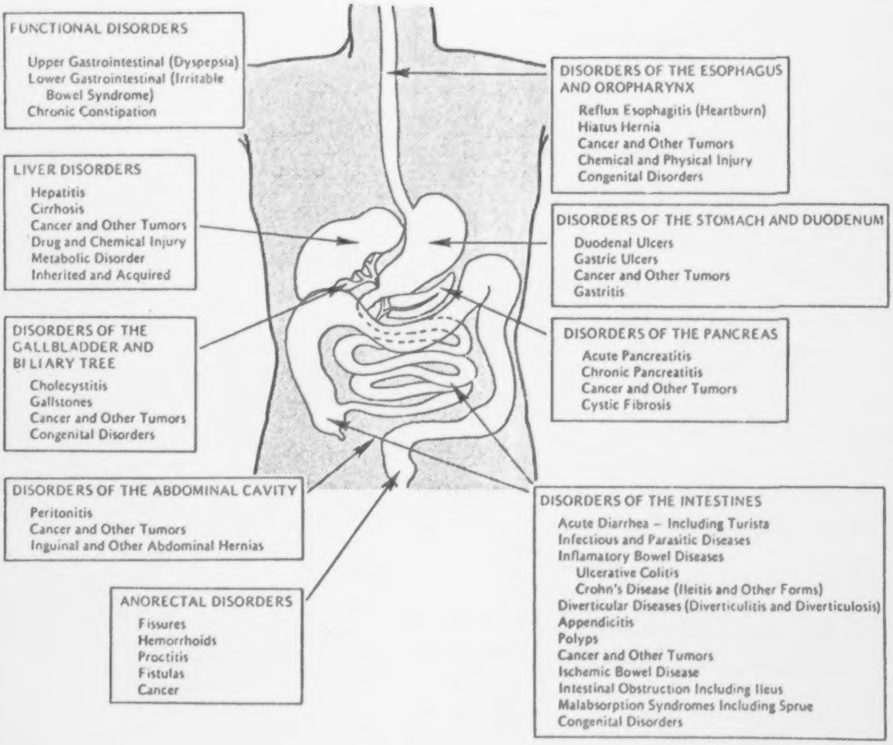
Until the cures are found, measures must be taken to improve the provision of information to patients, health care personnel and the public. The National Commission recommended the establishment and funding of a National Digestive Disease

Education and Information Clearinghouse. As indicated earlier, the Clearinghouse has been established but woefully lacks the funds for it to become an important and effective educational effort, and the funds that have been made available at the discretion of the NIADDKD leadership is taken from the already underfunded research program.

The hundreds of digestive disease patients, family members, union leaders, employers, physicians and nurses who testified before the Commission Hearings in ten U.S. cities across the nation expected more for their combined efforts. At this point, one would have to search long and hard to see evidence of even one of The National Digestive Disease Commission's recommendations implemented with appropriate funding resources.

Perhaps this newly constituted Senate Committee can and will make a difference. We would all hope so, for all of us will gain and benefit from the Digestive Disease Forward Plan which will significantly reduce the suffering of all Americans afflicted with digestive diseases and reduce the costs - both medical and societal - associated with digestive diseases.

COMMON DIGESTIVE DISEASES



FUNCTIONAL DISORDERS

Upper Gastrointestinal (Dyspepsia)
Lower Gastrointestinal (Irritable Bowel Syndrome)
Chronic Constipation

LIVER DISORDERS

Hepatitis
Cirrhosis
Cancer and Other Tumors
Drug and Chemical Injury
Metabolic Disorder
Inherited and Acquired

DISORDERS OF THE GALLBLADDER AND BILIARY TREE

Cholecystitis
Gallstones
Cancer and Other Tumors
Congenital Disorders

DISORDERS OF THE ABDOMINAL CAVITY

Peritonitis
Cancer and Other Tumors
Inguinal and Other Abdominal Hernias

ANORECTAL DISORDERS

Fissures
Hemorrhoids
Proctitis
Fistulas
Cancer

DISORDERS OF THE ESOPHAGUS AND OROPHARYNX

Reflux Esophagitis (Heartburn)
Hiatus Hernia
Cancer and Other Tumors
Chemical and Physical Injury
Congenital Disorders

DISORDERS OF THE STOMACH AND DUODENUM

Duodenal Ulcers
Gastric Ulcers
Cancer and Other Tumors
Gastritis

DISORDERS OF THE PANCREAS

Acute Pancreatitis
Chronic Pancreatitis
Cancer and Other Tumors
Cystic Fibrosis

DISORDERS OF THE INTESTINES

Acute Diarrhea – Including Turista
Infectious and Parasitic Diseases
Inflamatory Bowel Diseases
  Ulcerative Colitis
  Crohn's Disease (Ileitis and Other Forms)
Diverticular Diseases (Diverticulitis and Diverticulosis)
Appendicitis
Polyps
Cancer and Other Tumors
Ischemic Bowel Disease
Intestinal Obstruction Including Ileus
Malabsorption Syndromes Including Sprue
Congenital Disorders

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STATEMENT OF DR. ROBERT WELLS

Mr. Chairman, and members of the Committee, I am Robert Wells, M.D. I am in the private practice of orthopaedic surgery in Atlanta, Georgia and the President of the American Academy of Orthopaedic Surgeons.

I am pleased to have this opportunity to appear before you today to present the Academy's position on the need for continued and, if possible, expanded funding of research on the musculoskeletal system, as well as to request adequate funding for Emergency Medical Systems and physical fitness activities.

The American Academy of Orthopaedic Surgeons has a membership of approximately 9,000 Board Certified orthopaedic surgeons. Over 90% are in private practice. The primary objective of the Academy is to foster, promote, support and encourage investigative knowledge of orthopaedic surgery and the prevention of disorders of the musculoskeletal system.

The musculoskeletal system is a major system of the body, involving those anatomic elements of structural support essential to the function of the body as a whole. This includes, for example, bones, joints, muscles, ligaments and tendons.

It should be noted that musculoskeletal disorders are a leading cause of:

- confinement to hospitals and nursing homes;
- increasing cost of workers' compensation programs;
- increasing cost of Social Security Disability Insurance; and
- visits to doctors offices.

Studies conducted by the National Center for Health Statistics and Yale University School of Medicine show that one out of seven persons in the United States suffers from some form of musculoskeletal impairment. These impairments result in a significant decrease in an individual's ability to perform activities of daily living and cost society -in terms of lost earnings and medical expenses -- over $30 billion per year.

It should also be noted, Mr. Chairman, that musculoskeletal disorders and injuries affect all age groups. For example:

- hip and spine fractures and osteoporosis are common in the elderly;
- birth defects and inherited disorders of the musculoskeletal system often lead to permanent handicaps, as well as decreased life expectancy;
- joint problems affect more than fifteen percent of our population. Arthritis alone is the leading cause of restriction of mobility and ranks second only to cardiopulmonary disease as the leading cause of limitation of activity.

Thus, available data make it clear that musculoskeletal disorders and injuries have a significant impact on the citizens of this country, in terms of a reduced quality of life and high economic cost.

Musculoskeletal research has yield important recent advances. The use of electrical stimulation to promote healing in stubborn fracture problems is being used increasingly in clinical settings. Improvements in the use of chemotherapy measures are producing progressive results in bone sarcomas -- a particularly deadly form of malignant disease. Research studies in healing of collagen tissues are producing an improved ability to surgically repair ligament injuries -- a frequent cause of major disability in physically and athletically active Americans.

Although we have made substantial progress in treating musculoskeletal disorders, there is still considerable research to be done in order to better understand the causes of these disorders, to develop better treatment modalities and to develop prevention programs. For example:

- more research is needed in order to better understand the exact biologic process involved in growth plate activity and enchondral ossification. Studies of this type are needed so that skeletal deformity associated with growth plate disorders can be prevented or minimized;
- as frequently as fractures occur, the process by which fractures heal is not completely understood. Nonunion or failure of a fracture to heal is a serious and disabling complication of fracture repair. Studies must be supported to determine how matrix element deficiencies, hormonal deficiencies, enzyme deficiencies or generalized disease states predispose to fracture nonunion;
- studies must be supported in the areas of bone cell biology and calcium transport, investigation of Vitamin D, calcitonin and parathyroid hormone on bone tissue and investigation of bone structure abnormalities associated with disorders such as osteogenesis imperfecta and Paget's disease.

The fellows of the Academy recognize that Congress and the new Administration are struggling with difficult economic and financial problems. However, we firmly believe that research funding, including research training, is a social investment in the future, not a handout.

It is with this in mind that we respectfully recommend that the National Institute of Arthritis, Diabetes and Digestive and Kidney Diseases (NIADDKD) be appropriated $409 million for fiscal year 1982; and urge this Committee to direct NIADDKD to apply a substantial amount of these additional funds to support research in the prevention and treatment of arthritis and other musculoskeletal conditions.

Before I turn my attention to several other NIH Institutes, I would like to urge this Committee to direct NIADDKD to achieve equalization of funding throughout each of its ten program areas. The current distribution of funding within this Institute is unbalanced, resulting in high quality research applications in certain disease areas not being funded. This is a serious problem and it requires the attention of this Committee.

With regard to the National Institute on Aging, we recommend a funding level of $94 million, in order to support on-going research and, in particular, the special aging diseases of the bones, muscles, ligaments and tendons commonly found in the elderly.

Another Institute that we believe should be actively involved in musculoskeletal research is the National Institute of Child Health and Human Development. We recommend a funding level of $250 million, in order for this Institute to conduct research in the area of birth defects, growth disturbances, scoliosis and other spinal disorders affecting children and adolescents.

The problem of the handicapped individual is a costly one to society and a burden to the individual and his/her family. The work currently underway at the National Institute of Handicapped Research (NIHR) is beginning to help these individuals to become self sufficient and productive members of our society. Continued support of rehabilitative research is essential if the handicapped individual is to be given an opportunity to fully participate in the benefits of our society. We request the Committee to consider a funding level of $40 million for NIHR.

It has been said that physical exercise is a major therapy for the ill and the master conditioner for the healthy. On the other hand, unfit, poorly conditioned Americans are more susceptible to illness and injury. Therefore, it is important that our national government identify physical fitness as a high priority and that adequate funding be provided to Title 17 programs of the U.S. Public Health Service Act.

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The last area of interest I would like to speak to is the Emergency Medical Systems. This is a program that the orthopaedic community has been involved in from the start. In fact, the program came about in great part as a result of the work of our Committee on Injuries.

As orthopaedic surgeons, we see everyday the outstanding work of the advanced life support systems, staffed by trained personnel, in reducing the morbidity and mortality rate from accidents and other conditions. The success of the program is well documented in the literature.

The Academy supports a funding level of $33 million for the Emergency Medical Systems.

Mr. Chairman, on behalf of the American Academy of Orthopaedic Surgeons, I want to thank this Committee for its past support of biomedical research and, as you go through the process of marking up this appropriation bill, I urge you to keep in mind the need for a balanced biomedical research program at NIH. By that I mean support for all elements of the system -- basic research, training, clinical application and technology transfer. Unless an appropriate balance is maintained, the taxpayer who foots the bill for this work may not reap the benefits of his investment.

I will be happy to answer any questions.

STATEMENT OF DR. J. ALFRED RIDER, PRESIDENT, CHILDREN'S BRAIN DISEASES

Senator RUDMAN. The first to testify this morning is Dr. Alfred Rider, president of Children's Brain Diseases, followed by Dr. John Freeman of the Epilepsy Foundation and then Marjorie Guthrie and her associates from the National Committee for Research in Neurological and Communicative Disorders. Did I leave anybody out?

You know our rules, you know what the yellow light means? Very well. Proceed.

Dr. RIDER. I am Dr. Alfred Rider, president of the Children's Brain Disease Foundation. I have with me my son, Dr. Dean Rider, who has assisted us in the foundation work.

It is a pleasure to testify for your committee this morning in support of the budget request. I would specifically like to address myself to the need for continuing support of funds for research on Batten's disease. We were pleased with the wordings expressed in 1979–80 Senate committee report. Namely, that Batten's disease continues to be a high priority of the committee.

This is a neurological disease which may have an incidence as high as other diseases; such as, PKU and Huntington's chorea. It is a particularly devastating disease in that it manifests itself in otherwise normal children at a very early age. Increased effort in this area should also be provided by the Institute. We hope you will include this same wording in this year's report.

It is my understanding that at that time the appropriations subcommittee recommended to the NIH that specifically $625,000 would be set aside for research on Batten's disease. Although that inflationary rate remains high, we would hope that you would take into consideration the need for approximately a 6 percent yearly increase or $700,000 for research on Batten's disease in your appropriations to the NIH for fiscal year 1981–82, in order to maintain the present level of research.

It has only been in the last 13 years that an impetus for research on Batten's disease has occurred; largely, as a result of moneys from the Children's Brain Diseases Foundation and in the last 3 years by increased appropriations to and from the NIH.

Batten's disease is a neurological disorder which may have an incidence as high as 1 in 12,500 births, similar to other diseases such as PKU and Huntington's chorea. It manifests itself in previously normal children at the approximate ages of 4 to 8 and is characterized by a slow progression of clumsiness, stumbling, failure of vision, seizures, changes in personality, and dropping of scholastic grades. The disease eventually leaves them totally disabled and unable to care for themselves and usually ends in death in the late teens or early twenties.

One of the most promising theories about the disease has resulted from the discovery of lack of enzyme peroxidase in Batten's disease. This results in an accumulation of a yellow pigment, ceroid lipofuscin, in the brain cells producing slow destruction and progressive deterioration. These changes are quite similar to the changes that take place in all brains as they age; thus, effective treatment for Batten's disease might very well delay the normal aging process.

We are now perfecting a simple blood test to identify children with the disease and the carriers. Furthermore, there has been identified a strain of dogs and sheep who coincidentally and miraculously have a disease similar to Batten's disease in humans, thus providing an animal testing model.

Funds must be available to perfect the simple diagnostic blood tests, better elucidate the pathophysiology of the disease, assist with genetic counseling, and initiate and evaluate therapy; such as, feeding or injecting peroxidase and/or various antioxidants. It has been found, for example, that horseradish and avocado are high in peroxidase. Pure enzyme may be obtained from the placenta or from DNA-altered bacteria. Exciting recent research has shown that the blood brain barrier to the brain enzyme therapy can be penetrated.

Research is the only way to solve this disease and prevent the devastating tragedy in families who have children so afflicted and effect tremendous savings to society as a whole. The cost of care for each child is enormous and may be as high as $50,000 to $100,000 a year. Thus, 10 children such as these would cost more per year than the funds we are requesting.

Finally, the possible spinoff of enabling us to alter the aging process or senility in all humans makes the value of this research unlimited.

In the last year research has expanded and is progressing rapidly. This momentum must be maintained.

Because of the constraint on time, I cannot review the research studies underway, but I have enclosed them in the prepared addendum. Suffice it to say that there are over 20 principal investigators from major universities, medical centers and institutes throughout the United States and Canada involved in various phases of research pertaining to Batten's disease. If funding is provided, the chances of development of a specific treatment program in the foreseeable future appear to be very good.

Thank you.

Senator RUDMAN. I know you have come a long way to testify this morning and we appreciate it. Considering the caliber of some of the witnesses we have, it is too bad we don't have more time. I assure you we will read your written statement.

STATEMENT OF DR. JOHN FREEMAN, ASSOCIATE PROFESSOR OF NEUROLOGY, JOHNS HOPKINS SCHOOL OF MEDICINE, EPILEPSY FOUNDATION OF AMERICA

Dr. FREEMAN. I am Dr. John Freeman, and I am a member of the board of directors of the Epilepsy Foundation of America and the professional advisory board.

The Epilepsy Foundation is the grassroots voluntary organization concerned with the prevention and control of epilepsy. It is dedicated to improving the quality of life for the more than 2 million Americans who presently suffer from this disorder.

The foundation shares with our President, with Congress, and even with most Americans, the desire to combat inflation and the desire to decrease the cost of the Government. We would like to point out in our testimony the current cost of that to society, and to suggest that in this instance, the best way to save society money may be to spend it.

In 1975 the National Commission on the Epilepsies estimated that the cost of epilepsy to society was more than $3 billion—$1½ billion of this was in unemployment and underemployment and $1 billion in care. That was in 1975 dollars.

In contrast, only $13 million was spent on vocational rehabilitation and only $38 million in research.

We would suggest that an increased investment in research will lead to better understanding, better drugs, and better treatment and that this investment will be returned manifold by a decrease in cost of care.

We would suggest that an investment in education and rehabilitation can decrease the cost of unemployment and underemployment and returning the investment with impressive dividends and taxes for those who are now unemployed.

With good rehabilitation, with adequate counseling and teaching job-seeking skills and work habits, we can turn individuals from social security and welfare recipients into taxpaying, employed citizens.

The placement of labor has—over the past 5 years—found full-time competitive employment for 3,000 individuals at a cost of $400 per client. In the first year of employment these individuals repaid more than twice the cost of placement and we have seen even more impressive results on a local level in Maryland.

Appropriate education and training in school could prevent the need for rehabilitation later. Similarly, community living arrangements are providing opportunities for individuals with epilepsy to be removed from institutions and avoid entering—we are able to provide better and more compassionate living arrangements at far less cost to society.

Perhaps our most important investment is in research. This was a longer term investment that pays even greater dividends. The epilepsy branch at NINCDS has, in the past few years, revolutionized the field of epilepsy and affected the lives of all people with it. Research on drug metabolization has been done to more effectively control the seizure.

Countless thousands of individuals previously incapacitated by their seizures are now completely controlled and employable. The branch is actively searching for new drugs which will bring control to the 20 or 30 percent of representatives who are now partially controlled and the 20 percent who remain uncontrolled.

Through the comprehensive epilepsy centers new techniques for therapy and rehabilitation are being developed. Educational materials have been produced which are educating professionals and the public about epilepsy and eliminating the biases and discrimination which are the major barriers to employment of people with epilepsy. The longer range basic research sponsored by NINCDS is searching for a better understanding of brain function, understanding the basic physiology of neurotransmittors and of anatomical pathways which will eventually allow understanding and cure of epilepsy as well as other neurologic disorders. This research cannot and should not be targeted at solely one neurological disorder, for the basic research in one field often provides the clues that are essential to understanding other fields and other neurological disease.

Currently, NINCDS funds $14 million; society pays more than $3 billion for care of people with epilepsy. It is not hard to see how money could be saved and reduce only a fraction of the cost.

The proposed NINCDS budget is $227 million. Thoughtful professionals are asking for $340 million. This will allow the funding of 61 percent of the approved research grant whereas current proposed budget will allow only 39 percent. It would appear to me and the Epilepsy Foundation that this increased investment would be sound, would be well spent, and would be repaid in manifold in direct cost savings to society to say nothing of the improvement in well being of those who have epilepsy and other neurologic disorders. Thank you.

Senator RUDMAN. Thank you very much. We would like you, to the extent possible, to not go over your time too much. We are on, as I said, a very tight schedule this morning.

STATEMENT OF MARJORIE GUTHRIE, COMMITTEE TO COMBAT HUNTINGTON'S DISEASE, NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS

Ms. GUTHRIE. Senator Rudman, I am Marjorie Guthrie and I am not a physician. I am a concerned citizen. And as I sit here today, I think I was here 10 years ago coming because I had a husband who died of Huntington's disease. Today I am sitting here proudly because I don't represent Huntington's disease, I represent a coalition who represents 50 million American people whose problems are the brain and central nervous system.

Now all of these people sitting here with me are scientific people, physicians, who have educated me. And I say if you can educate me, I can educate you.

I am a dancer, and I have learned that the problem is the brain and central nervous system and this is what we are interested in telling you today. That is, to the Congress.

There has been an increase of support for our institute for the last few years. Because we fought as a coalition. We didn't come here disease by disease by disease. We are proud of this.

I am concerned today that you should hear us speak as a coalition that represents so many of the well known disorders that you have heard about and so many of those that you have not heard about. Very rare disorders of the central nervous system.

If you ask us why don't the volunteers do more in research, we have a twofold problem. We have to do our work in supporting services as well as research and we can't do both without the help of the Congress. The Congress does have to continue its wonderful support, that it has been giving to the neurologic institute. And we are asking you today to consider that again. And I would remind you that these remarkable research proposals that have come before the Congress and have been supported has resulted in some wonderful Nobel Prizes. So it has been paying off.

And we, as the citizens, are grateful that there has been this kind of interest. We want to see it promoted. We want all of our 50 million people that we represent who can't come here and testify because they are in wheelchairs or stuck in chronic disease care facilities, to know we are interested. You must do your share, too. We can't do it without you.

The other people sitting here on the panel will introduce themselves. We want you to listen to them and help us do something for the future of these people who otherwise spend 20 years and more with their families struggling with these various disorders of the brain and central nervous system. Thank you for listening.

Senator RUDMAN. Thank you very much, Mrs. Guthrie.

STATEMENT OF DR. BYRON WAKSMAN, RESEARCH DIRECTOR, NATIONAL MULTIPLE SCLEROSIS SOCIETY

Dr. WAKSMAN. I am Byron Waksman, director of the research program for the National Multiple Sclerosis Society. I am here to second the remarks you just heard from Marjorie Guthrie.

My credentials are; I was a faculty member of Harvard University Medical School for 15 years, and another 15 years a faculty member at Yale Medical School. I served as chairman of the department.

I have been president of the Professional Scientific Society, American Society of Immunologists, and in my present capacity I administer a $6 million program of research grants related somehow to multiple sclerosis.

One of the things Marjorie Guthrie said which is most important is that fundamental research which is, we hope, will solve not only the disease I am interested in, multiple sclerosis, but many of the others you have been hearing about this morning. This can only proceed if Congress gives it adequate support. The voluntary agencies simply cannot do this.

The principal research support of the Nation is that which comes from Congress and if it is reduced or disappears, the enterprise in this country has had it.

Now you have been hearing the same themes from almost all of the speakers. I would, of course, acquiesce that they are the principal themes. There should be support for NINCDS at a level which at least equals inflation, or goes beyond it. I don't believe inflation is 9½ percent. The truth is more like 14 to 15 percent. But the research is such that one must provide for growth. With every new discovery, in the basic sciences, one has to have a new research area related to the diseases that may depend upon that discovery. So a rational research support program from Congress must provide for at least modest growth, beyond the level of what is reached with inflation.

I think that there should be support for those Institutes at NIH which provide the basic concepts and techniques that NINCDS uses, such as the Institute for General Sciences, and the Institute for Allergy and Medical Diseases which provides us with basic knowledge of immunology.

But the basic solution to multiple sclerosis, Huntington's disease, and the rest of them will be done with the support of NINCDS.

I might say a word about science and business, or science and industry. In an industry you can usually set benchmarks and say by September 1982 we will have done such and such. By September 1985 we will have found the virus and by September 1987 we will have the vaccine. By 1989 we will have tested the vaccine.

Well, in basic research, things don't work that way. You depend on the creative acts of individual scientists who synthesize all that is known at the time and do experiments to forward their own ideas. And we cannot solve these very complex diseases which confront us at the present time without continued strong support.

Two last points. The research enterprise is very fragile. If you turn off a major research lab by reducing its funding, people leave who cannot be replaced and they cannot remember science if they are out of science for any length of time. They lose their contact with what is going on.

So stability of funding is certainly the most important thing.

Second, the training which everyone here has addressed, is equally important. The scientific enterprise does not just require replacement of those who die. It requires new people, with new ways of looking at things. It cannot proceed without that. Thank you very much.

Senator RUDMAN. Thank you very much, doctor.

STATEMENT OF DR. ROBERT RUBEN, CHAIRMAN, OTORHINOLARYNGOLOGY DEPARTMENT, ALBERT EINSTEIN SCHOOL OF MEDICINE

Dr. RUBEN. I am Bob Ruben, professor and chairman of the department of otorhinolaryngology at Albert Einstein Medical Center. I am also vice president of the National Committee of Research represented by Mrs. Guthrie and the rest of us.

What I would like to talk about for a little while today is the problem of communicative disorders. A specific example of a rather endemic problem.

By communicative disorders I mean those disorders of voice, speech, language, and hearing. Really, the very things that make us human. My ability to speak to you, my ability to understand what you say. This is a disease that effects approximately 10 percent of the population, one out of four people over 65 alone just have a substantive hearing loss. Estimated cost, $23 to $28 billion.

But to the point that I would like to make, just to use one small example. The problem of genetic disease which may account for almost one-half of the problem. Here we have a very critical shortage of manpower which is even more alarming to face the discoveries that have been made.

Sitting to my left and sitting to my right are neurological colleagues who have begun to define biochemically and use prevention and cure for treatment of diseases of the nervous system and not deafness.

Only about three people are working with the genetic disease of deafness. Even more alarming, in the last council of January, there were 87 grants proposed—6 of which were proposed by clinical otorhinolaryngologists. Out of the six, only one was approved and funded.

This was a disastrous situation because the individuals who have the unique knowledge to apply the basic science to the clinical problems are those men and women trained in clinical otorhinolaryngology.

The number of people that we are able to train has diminished to a point which is below the critical mass. What this means, is that to the American people, the advances made in basic science probably will not be applied to the eradication of their diseases. I guess, being in ears, noses, and throats, I run against the tide. I will run against the tide again and I will say I am seeking funds for training of clinical investigators in communicative disorders with a special emphasis on otorhinolaryngology which I think goes with what you heard from the gastrointestinal people and ourselves.

Ms. GUTHRIE. May I ask something?

Senator RUDMAN. We are running short of time, but, yes, you may.

Ms. GUTHRIE. To give you an example of the event, 5 years ago when the Society of Neurosciences met at their first meeting there were 500 neuroscientists. This year there were 7,000. Something has happened, and that has to be supported because it is good for the people of this country. That is a short story but I think an important one.

Senator RUDMAN. Thank you Mrs. Guthrie. I believe that concludes everyone in your panel. I thank you all for taking the time to give us your knowledge and your views and I am sure our chairman, Senator Schmitt, will be very mindful of your testimony and we will certainly give it as much weight as we can. Thank you.

[The statements follow:]

STATEMENT OF DR. J. ALFRED RIDER, PH. D.

I am Dr. J. Alfred Rider, President of the Board of Trustees of the Children's Brain Diseases Foundation. It is a pleasure to testify before the Senate/Labor Subcommittee on Appropriations and support the budget requests of the National Institute of Neurological and Communicative Disorders and Stroke.

I would specifically like to address myself to the need for continuing the support of funds for research on Batten's disease. We were pleased with the wording as expressed in the 1979-1980 Senate Committee Report; namely, "Batten's disease continues to be a high priority of the Committee. This is a neurological disease which may have an incidence as high as other diseases; such as, PKU and Huntington's chorea. It is a particularly devastating disease in that it manifests itself in otherwise normal children at a very early age. Increased effort in this area should also be provided by the Institute". We hope you will include this same wording in this year's report.

It is my understanding that at that time the Appropriations Subcommittee recommended to the N. I. H. that specifically $625,000 be set aside for research on Batten's disease. Although the inflationary rate remains high, we would hope that you would take into consideration the need for approximately a 6% yearly increase or $700,000 for research on Batten's disease in your appropriations to the N. I. H. for the fiscal year 1981-1982, in order to maintain the present level of research.

It has only been in the last 13 years that an impetus for research on Batten's disease has occurred; largely, as a result of monies from the Children's Brain Diseases Foundation and in the last three years by increased appropriations to and from the N. I. H.

Batten's disease is a neurological disorder which may have an incidence as high as 1 in 12,500 births, similar to other diseases such as PKU and Huntington's chorea. It manifests itself in previously normal children at the approximate ages of 4 to 8 and is characterized by a slow progression of clumsiness, stumbling, failure of vision, seizures, changes in personality and dropping of scholastic grades. The disease eventually leaves them totally disabled and unable to care for themselves and usually ends in death in the late teens or early twenties.

One of the most promising theories about the disease has resulted from the discovery of a lack of the enzyme peroxidase in Batten's disease. This results in an accumulation of a yellow pigment, ceroid lipofuscin, in the brain cells producing slow destruction and progressive deterioration. These changes are quite similar to the changes that take place in all brains as they age; thus, effective treatment for Batten's disease might very well delay the normal aging process.

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Research is the only way to solve this disease and prevent the devastating tragedy in families who have children so afflicted and effect tremendous savings to society as a whole. The cost of care for each child is enormous and may be as high as $50,000 to $100,000 a year. Thus, 10 children such as these would cost more per year than the funds we are requesting.

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In the last year, research has expanded and is progressing rapidly. This momentum must be maintained.

Because of the constraint on time, I cannot review the research studies underway but I have enclosed them in the prepared Addendum. Suffice it to say that there are over twenty principal investigators from major universities, medical centers and institutes throughout the United States and Canada involved in various phases of research pertaining to Batten's disease. If funding is provided, the chances of the development of a specific treatment program in the forseeable future appear to be very good.

ADDENDUM

SCIENTISTS ACTIVELY WORKING IN RESEARCH ON BATTEN'S DISEASE

1. Donald Armstrong, M. D.
   Assistant Professor of Neurology
   University of Colorado Medical School
   a) Relationships of Peroxidase to Batten's Disease
   b) Canine Retinal Degeneration: An Approach to Therapy
   c) Peroxidase Deficience & Peroxidase Regulating Enzymes

2. James H. Austin, M. D.
   Professor and Chiarman, Department of Neurology
   University of Colorado Medical School
   a) Treatment of Batten's Disease with Peroxidase

3. Robert J. Baumann, M. D.
   Department of Neurology
   University of Kentucky & Section on Epidemiology OBE,
   Office of the Director, N.I.N.C.D.S., Bethesda, Maryland
   a) Leukocyte Ultrastructure

4. Milton Brightman, M. D.
   Lab. of Neuropathology & Neuroanatomical Sciences
   N.I.N.C.S. & National Institutes of Public Health/HEW
   a) Transport of Horseradish Peroxidase across Blood brain Barrier

5. Glyn Dawson, Ph. D.
Associate Professor, Depts. of Pediatrics and Biochemistry
The University of Chicago
a) Pre-Natal Diagnosis and Enzyme Replacement Therapy

6. Edward Dratz
Associate Professor of Chemistry & Biochemistry
University of California, Santa Cruz
a) Measurement of Fluorescent Lipopigment, Peroxidized Fatty Acids, Vitamin E, Effects of Antioxidants on Lipopigment Formation

7. Denham Harman, M. D.
The University of Nebraska Medical Center
a) Brain Lipid Composition

8. K. U. Ingold, Ph. D.
Assoc. Director, National Research Council of Canada
Division of Chemistry
a) Resistance to Oxidation and the Natural Antioxidant Levels in Membranes from Human Cells

9. Edwin H. Kolodny, M. D.
Associate Director, Eunice Kennedy Shriver Center for Mental Retardation, Inc., Waltham, Massachusetts
a) Pathogensis of the Neuronal Ceroid-Lipofuscinoses

10. Martin M. Maltempo, Ph. D.
Assistant Professor of Physics
University of Colorado Medical Center
a) Monitoring of Peroxidase and Free Radicals in Canine Retinal Tissue Subject to a Degenative Disease in Which There is an Accumulation of Pathologic Lipopigments of the Ceroid Type: A Model for Batten's Disease

11. Jaime Miquel, Ph. D.
NASA, Ames Research Center, Moffett Field, CA
a) Analysis of Pigment Lipofuscin

12. Vimal Patel, M. D.
Assistant Professor of Pathology
Indiana University School of Medicine
a) Antioxidant Treatment of Batten's Disease

13. Alan K. Percy, M. D.
Associate Dean, Office of Research
Charles R. Drew Postgraduate Medical School, Los Angeles
a) Solutory Effect of Selenium, Erythrocyte Glutathione Peroxidase

14. Michel Philippart, M. D.
Neuropsychiatric Institute
University of California, Los Angeles
a) Treatment of Batten's Disease with Antioxidants

15. Mark Poznansky, M. D.
Associate Professor of Pathology
University of Alberta
a) Enzyme Replacement and Enzyme Engineering

16. Raju Pullarkat, M. D.
New York State Institute for Basic Research in Mental Retardation
a) Lipopigments in Aging and in Ceroid-Lipofuscinoses

17. Julius Schultz, M. D.
    Director, Pananicolaou Cancer Research Institute
    Miami, Florida
    a) Discovery and Characteristics of Leukocyte Peroxidase and the Purification and Administration to Animals

18. Aristotle Siakotos, M. D.
    Professor of Pathology
    Indiana University Medical Center
    a) Development of a Reliable Blood Test for Batten's Disease Through Studying Koppang Dogs

19. Satish Srivastava, Ph. D.
    Department of Human Biological Chemistry & Genetics
    The University of Texas Medical Branch
    a) Purification and Properties of Leukocyte Peroxidase
    b) Biochemical Studies in Neuronal Ceroid-Lipofuscinoses

20. Al Tappel, Ph. D.
    Division of Food Science & Technology
    University of California, Davis
    a) Properties and functions of Glutathione Peroxidase and Pentane Analysis of Lipid Peroxidation Damage to Quantitate Effects in Nutrition

21. John R. Wherrett, M. D.
    Professor of Neurology Program
    University of Toronto
    a) Isolation of Fluorescent Material in the Juvenile Form of Batten's Disease

22. Leon Wolfe, M. D.
    University of California, San Diego
    a) Characterization of the Accumulated Retinol Compounds in Batten's Disease
    b) An Analysis of Urine Sediment in Subjects with Batten's Disease

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STATEMENT OF DR. JOHN FREEMAN

INTRODUCTION:

John Mark Freeman, M.D. is a graduate of Amerherst College and of the Johns Hopkins School of Medicine. He is the Director of the Pediatric Seizure Clinic at Johns Hopkins Hospital and a member of the Board of Directors and the Professional Advisory Board of the Epilepsy Foundation of America.

MR. CHAIRMAN:

The Epilepsy Foundation of America is pleased to take this opportunity to share with the Committee our recommendations on Labor-HHS-Education Appropriations for fiscal year 1982.

The Epilepsy Foundation of America is the grassroots voluntary organization concerned with the prevention and control of epilepsy and with improving the quality of life for the two million Americans who presently suffer from the disorder.

Few handicaps have been so mysterious and so misunderstood as epilepsy. The person with epilepsy and the family must cope with the adverse effects of the disorder, with expensive medical care, limited employment opportunities and difficult social adjustment.

The people of the Unites States, through their elected representatives, have created a set of programs that help address the needs of people with epilepsy. At this time when the attention of the President, the Congress and the public is focused upon economic stimulation, limiting federal spending and the transfer of programs to state and local control, we urge you to remember that there are at least two million people with epilepsy in this country who still have severe medical bills, still suffer unemployment and underemployment and still need the drugs which federal research funds make possible.

The Epilepsy Foundation of America joins with the President, the Congress and all Americans in the desire to combat inflation, eliminate waste in government and reward enterprise and initiative. We are prepared to work with you to help find ways to make the government work more efficiently and effectively. In the rush to cut government spending, however, we urge you not to overlook several vital points.

First, we would like to point out that many government programs are cost effective. They are investments, like any business investments, that bring financial rewards to the investor. For example, an investment in research and preventive health programs now can save the government many times over in future medicare and medicaid payments plus other health care costs. Investments in special education, job training and placement programs which enable the handicapped to become self-sufficient have demonstrated a reduction in federal expenses for welfare, food stamps, SSI, etc. Furthermore, participants in these programs have become taxpayers now able to contribute to the federal treasury. We urge you to look at these programs to determine whether they drain the federal budget or contribute to it. Among such programs, the Epilepsy Foundation of America is particularly interested in CETA Title III National Programs and Title II and VI Public Service Employment; Special Education; and Vocational Rehabilitation.

Secondly, not all programs can or should provide a financial return to the Treasury, but they are legitimate and necessary functions of government. Virtually all Americans agree that people with handicaps are entitled to special treatment and assistance from a just and compassionate society. We do not believe that the American public voted last November to eliminate or even reduce programs such as Comprehensive Centers for Independent Living, Developmental Disabilities programs and mental health programs. These programs and others combine to make life less harsh for people with serious handicaps and their families.

Third, we wish to point out that several vital categorical programs would be lost if they were folded into block grants. Without them, people with epilepsy and other disorders requiring specially tailored services will suffer. We refer specifically to the Developmental Disabilities programs, Vocational Rehabilitation and Special Education.

It may be that efficiencies can be achieved through decentralized decision making for large programs in labor, health, human services and education that serve large and easily identified publics. However, the record is clear that small, target populations with special needs, often the most severe needs, are frequently overlooked or underserved at the state and local levels. This is not due to malice or lack of concern on the part of state and local officials. Rather it is due to a lack of specialized expertise at these levels that is necessary to understand and deal effectively with the particular needs of these population groups. It was for these reasons that specialized categorical programs were developed.

Unlike most other special population groups, people with handicaps are geographically scattered and, partly due to their handicaps, less able than others to band together to create the visibility and clout needed to draw attention to those needs. Thus, their needs have often gone unrecognized and unmet. We urge you to refrain from folding the categorical programs currently meeting those needs into block grants. We have discussed these in greater detail in a written statement submitted to you.

Finally, but most importantly, there are governmental programs which do not generate direct economic return and do not provide immediate services to people in need. Yet these programs provide the very foundation of progress, and, if we may quote the President, "progress is our most important product!" We refer, of course, to research. Research enables us to discover new technologies and make progress in energy pro- tion, space exploration, industrial development and in the prevention, treatment and cure of illnesses and disorders. The Epilepsy Foundation of America, on behalf of the two million people with this disorder, urges you to increase this nation's investment in medical research, particularly research which will lead to the prevention of, better control of and eventually a cure for epilepsy.

The primary agency for this research is the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS). NINCDS, with a current budget of nearly $254 million has responsibility for approximately 600 different neurological disorders. The basic neurological research supported by NINCDS benefits no single condition exclusively.

Rather it provides a vital basis for progress in all of them. Of the $254 million, approximately $14 million is devoted to epilepsy. The Epilepsy Branch of NINCDS, which began in 1966, provides for direct and grant supported research programs for new methods in prevention, diagnosis and improved treatment of epilepsy. Some 60 of the more than four hundred recommendations in the 1977 Report of the Commission for the Control of Epilepsy and Its Consequences concern needs for additional research within the purview of NINCDS.

A vital component of the Epilepsy Branch is the Antiepileptic Drug Development Program. Funding for drug research in epilesy is particularly important because the population at risk (estimated to be approximately 1% of the total population) is not large enough to make research on anticonvulsant drugs commercially attractive. New anticonvulsants thus fall into that category labled "orphan drugs". Because of the research funded by NINCDS, we now have drugs which effectively control seizures for 50% of people with epilepsy. Another 30% realize partial control. Available drugs are not effective for the remaining 20%.

In other words, approximately one million people are able to lead virtually normal, productive lives because taxpayers, expressing their concern and will to help through their elected representatives, have provided the resources for effective drug research which would not otherwise have been undertaken. We can all be proud of our part in this achievement.

The task is far from over, however. There remain some 600,000 people with only partial relief from seizures, and 400,000 with virtually no relief. Furthermore, the currently available drugs which prevent or reduce seizures often cause debilitating side effects. Researchers are seeking new drugs and variations on existing formulas that will minimize side effects and that will achieve complete control of seizures for all victims of epilepsy. Such research has an additional potential value to society. Individuals who suffer frequent seizures are not able to find employment and are forced to depend on Social Security or welfare benefits. New drugs to control their seizures would make it possible for them to be independent and contribute to rather than receiving help from our society.

Under a contract with the Epilepsy Branch, the University of Utah is screening new chemicals received from academic institutions and the pharmaceutical industry. There are also agreements to screen new chemicals from different pharmaceutical industries in Europe. Some 5,000 components have been screened and of these, several dozen look extremely promising.

Another vital component of the Epilepsy Branch is know as the Comprehensive Epilepsy Programs. These programs are funded by contract to conduct clinical and laboratory research in the diagnosis, treatment, prognosis and prevention of epilepsy. The programs demonstrate to physicians and other professionals the most recent advances in epilepsy research and treatment, and they establish a program for public education. Inpatient facilities are made available to patients for periods of three to six months to receive special diagnostic evaluation and intensive treatment of their seizure disorder. The program integrates the management of patients with epilepsy for professionals, paraprofessionals and the lay public.

The cost effectiveness of such research and development has been demonstrated. Improved seizure control has allowed approximately ten to fifteen percent of institutionalized patients to be discharged to their homes; others are sufficiently controlled so they do not present appropriate cases for further studies in the institution.

The Epilepsy Branch of NINCDS has made a tremendous impact on the lives of people with epilepsy and their families. Whether that impact can or should be measured in purely financial terms is debatable. We cannot say with certainty that people with epilepsy are able to pay more in taxes than the research costs after becoming employable specifically as a result of taking medication developed by NINCDS. Perhaps they do. Probably they do. But more importantly, these people are able to lead more normal and fulfilling lives.

As research continues and new anticonvulsants with less severe side effects are developed, people with epilepsy will be able to become more productive. But we would hope that our values have not reached to the point that economic return is the only justification for federal support of research. The quality of human life, the ability to participate in one's society, and to control one's own day to day activity should be equally valued.

The Carter administration recommended a budget of $281 million for NINCDS for FY 1982. This recommended increase was largely in response to the virtual explosion in research developments in the neurological sciences. The $281 million budget would allow for funding of about 34% of the approved research projects. Within this budget, research project funds would increase by 15% but research centers would receive minimal increases.

The Reagan administration has recommended a funding level of $276 million. This level of funding, while larger than the current appropriation, would effectively reduce the level of research as it would not keep up with inflation. The opportunity to bring to fruition new developments currently underway would be jeopardized.

Neither the Carter nor the Reagan administration recommended funding at the level deemed optimal by NINCDS professional judgment. The optimal funding level is $340 million and the Epilepsy Foundation of America joins with the National Committee for Research in Neurological and Communicative Disorders in urging you to adopt the optimal level. These funds are essential to maintain the momentum of research breakthroughs of the past decade.

STATEMENT OF MARJORIE GUTHRIE

On behalf of the National Committee for Research in Neurological and Communicative Disorders I want to thank you for the opportunity to appear before this Committee with regard to the President's proposed budget for the National Institute for Neurological and Communicative Disorders, Stroke for FY82. Our committee, as you know, represents about 50 voluntary and professional organizations. A roster of our members is attached. Altogether we represent approximately 50 million persons in the country, including patients and their families, who receive health care and treatment related to their disorders that cost an estimated $20 billion a year. And projections for the field indicate that the numbers of individuals and costs will continue to increase each year until research not only develops new techniques for diagnosis, prevention and cure, but also unlocks the door to the root causes of the disorders through basic neuroscience research.

Recently President Reagan has proposed that the funding level for NINCDS for FY81 be reduced to $247 million, and $276 million in FY82. This compares to $253 million appropriated by the U.S. Congress for FY81 and $281 million proposed by the Carter Administration for FY82. This means that the Institute will receive, for FY81, only a three percent increase over FY80, or approximately nine percent below the inflation rate.
Mr. Chairman, the field cannot receive a reduction of this magnitude and be expected to progress toward the alleviation of the many disorders that are chronic and therefore costly in nature. Already training funds for the NINCDS have been reduced by over one-quarter during the past decade. The funding for the university research centers and the contract programs have suffered a real dilution in funds due to inflation. A reduction in the amounts suggested by the Reagan proposed budget will not, therefore, trim the fat out of programs, but will cause projects to founder and many of them to go out of existence because they simply cannot perform the necessary work and meet expenses.

Meanwhile the costs for treatment of chronic disorders will continue to rise and physicians will be forced to treat such conditions with little hope for either an immediate or future cure or amelioration of the problem. Patients' families will be told that neurological and communicative disorders research is at a standstill and that all promising breakthroughs will just have to await further exploration for budgetary reasons. There will be little room for optimism.

Let us look at one aspect of the research that NINCDS conducts and examine the impact that continued and increased research might have on it. Recently, the NINCDS produced The National Head and Spinal Cord Injury Survey which measured such injuries, their occurrence and the cost of treatment for same in one year. The NINCDS began negotiations for a number of such surveys in 1974 in order to provide both NIH research planners and the U.S. Congress with data for assessing research needs and settling research priorities in the United States. The National Head and Spinal Cord Injury Survey is the first published work to emerge from this NINCDS initiative and should prove invaluable to policy makers. Three others will be published during the next three years. However, such surveys are costly and the NINCDS has had to slow down its work on them due to an insufficiency of funding for this activity. Yet in a field as relatively new and exciting as the neurological sciences, such surveys are necessary. When one realizes that as short a time ago as 10 years, neuro-scientists were completely unable to examine the central nervous system, which is fully encased in bone, without performing major surgery; it is easy to understand why data has been scarce. Today, due to the advent of great advances in neuroradiology with the CAT scanner, examination and diagnosis have been revolutionized. The national surveys, therfore, are an attempt to order such knowledge and begin to organize our experience of the past decade in a coherent fashion.

The National Spinal Cord Injury Survey deals with disorders such as injury to the head and spinal cord, which often results in death or irreversible motor and sensory deficits. The medical problems of persons who survive such an injury are monumental, and the impact on our society of the costs and uses of medical resources for these problems is enormous. With regard to this group of injuries alone, American families are faced with nearly $4.5 billion in costs if no treatment and cure is discovered for such injuries.

Another disorder in which we are interested — Huntington's Disease — often lasts for ten years or longer. It requires that a patient stay in a nursing home an average of 7 years at a cost of at least $24,000 a year. Put in such a context, the $340.4 million that the National Committee for Research in Neurological and Communicative Disorders has recommended for NINCDS funding for FY82 would be well spent and not an inordinate amount. In fact, the NINCDS National Research Strategy for

Neurological and Communicative Disorders which produced a five-year plan for such research, recommends that an optimal level of $345.8 million be spent in 1981; its recommendation for 1982 is $419.2 million. Given that recommendation, the NCRNCD has scaled down its recommendation a great deal by projecting an expenditure need of only $340.4 million for FY82. Even with this amount, the NINCDS would be operating at a funding level fully one year and some $79 million below the optimal level envisioned by the prestigious group pf scientists that comprised the panel which formulated the planning strategy.

I would also like to point out that the bulk of the funding for Neurological and Communicative Disorders research must come from the federal government. Private voluntary agencies such as those which the NCRNCD represents cannot provide both services and support for research in the magnitude that it warrants.

The explosion of knowlege and interest in the field to which I referred recently has caused the already overtaxed research funds of the private organizations to be even less responsive today than they were as short a time as five to six years ago.

For instance:

— Paralyzed Veterans Association has received requests for $2.4 million in research funds this past year, or a five-fold increase in requests over the previous year.

— The American Narcolepsy Association has experienced a 400 percent increase in requests for its limited research funds during this year.

— The Muscular Dystrophy Association last year spent approximately $20 million in research on 760 different research projects. They expect this year's funding level to be even higher.

— The Amyotrophic Lateral Sclerosis Society has received requests for about $1.6 million in research funds in the past year, necessitating a doubling of its grant applications review process.

— National Ataxia Foundation increased its funding level 54 percent during the past year.

— The National Multiple Sclerosis Society has experienced a 25 percent increase in the number of requests for support with an accompanying 88 percent increase in the amounts sought, the average being about $171,000.

— The National Huntington's Disease Foundation which grants research fellowships, has received a five-fold increase in the number of applications.

- The Committee to Combat Huntington's Disease has registered a 50 percent increase in the number of research awards requested thus far this year.
- The Deafness Research Foundation has been averaging a 25 percent increase in the number of applications for awards.
- The American Heart Association, Stroke Council, reports that there was an 80 percent increase in applications for research this year.
- The National ALS Foundation reports that they have experienced a 100 percent increase in applications for their fellowships.
- The Hereditary Disease Foundation has logged a 35 percent rise in applications.

NINCDS is the major vehicle for the conduct of biomedical research in the neurosciences and related disorders. You have already received testimony from them regarding the major areas where break-throughs have occurred, including enzyme deficiency disorder diagnosis and treatment, the combination drug regimen for treatment of brain tumors, animal research on Amyotrophic Lateral Sclerosis, origins of Myasthenia Gravis disease, spinal cord regeneration basic research, and brain involvement during epileptic seizures. The NINCDS provides approximately 67 percent of all research dollars going to basic neurological and communicative disorders research. Included in this category is research on: narcolepsy, amyotrophic lateral sclerosis, brain tumors, learning disabilities, Huntington's Disease, deafness, hereditary disease, muscular dystrophy and other neuromuscular disorders, including myasthenia gravis, birth defects, multiple sclerosis, Reyes syndrome, Down's syndrome, spinal cord injury, stroke, Tourette syndrome, autism, cerebral palsy, epilepsy, spina bifida, Friedreich's ataxia, Alzheimer's disease, diabetic neuropathy, dystonia, metabolic errors such as Tay Sachs, inherited disorders such as neurofibromatosis as in The Elephant Man, Tuberous Sclerosis and many other related disorders. Because such a large percentage of research dollars for these disorders come from the Federal government, a reduction in its funds will have a resounding negative impact throughout the field.

Mr. Chairman, there are few of us here whose lives have not been touched by one of these tragic disorders. Those few have yet to face the aging process and the onset of stroke, senile dementia, Parkinson's Disease, diabetic neuropathy, secondary brain tumors or one of the many other disorders associated today with aging. This Institute holds the key to the research which will help alleviate some of these conditions and develop new treatment for others. Furthermore, it is only in the basic neuroscience research into root causes that we can hope to find the solutions to such disorders. We cannot afford to let this research falter now.

ROSTER OF MEMBERSHIP

Voluntary Health Organizations

American Narcolepsy Association
American Paraplegia Society
Amyotrophic Lateral Sclerosis Society of America
Association for Brain Tumor Research
Association for Children with Learning Disabilities
Committee to Combat Huntington's Disease
Deafness Research Foundation
Dysautonomia Foundation
Hereditary Disease Foundation
Muscular Dystrophy Association
Myasthenia Gravis Foundation
National ALS Foundation, Inc.
National Ataxia Foundation
National Easter Seal Society for Crippled Children and Adults
National Huntington's Disease Association
National Multiple Sclerosis Society
National Neurofibromatosis Foundation
National Spinal Cord Injury Foundation
Paralyzed Veterans of America
Parkinson's Disease Foundation
Stroke Council of the American Heart Association
Tourette Syndrome Association, Inc.
United Parkinson Foundation
Center for Neurologic Study

Professional Societies

American Academy of Neurology
American Academy of Otolaryngology
American Association of Electromyography and Electrodiagnosis
American Association of Neurological Surgeons
American Association of Neuropathologists
American Broncho-Esophagological Association
American Electroencephalographic Society
American Neurological Association
American Otological Society
American Society for Neurochemistry
American Society of Neuroradiology
American Speech, Language and Hearing Association
Association for Research in Nervous and Mental Disease
Association for Research in Otolaryngology
Association of University Professors of Neurology
Child Neurology Society
Congress of Neurological Surgeons
Neurosurgical Society of America
Society for Neuroscience
Society of Neurological Surgeons
Society of University Otolaryngologists
Triological Society

STATEMENT OF DAVID H. COHEN, PH. D.

As President-elect of the Society for Neuroscience I speak on behalf of more than 7000 brain scientists in North America. We submit our statement as part of the testimony of the National Committee for Research in Neurological and Communicative Disorders and fully support their recommendations.

The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) is the single most important source of support for brain research in this country, and the Institute's programs have clearly been instrumental in the explosive advances over the past decade in our understanding of the brain and its diseases. These include, by way of illustration, critical information on the basic pathways of the nervous system and the chemical messengers used by the nerve cells constituting these pathways. Such information on the chemistry of communication among nerve cells has been fundamental to developing treatments of disorders such as Parkinsonism and myasthenia gravis, and ongoing research in this area has substantial promise for contributing to the treatment of major debilitating disorders such as senile dementia. Analogously, research in the area of neuroimmunology is generating considerable optimism that an understanding of multiple sclerosis may be near at hand.

Neuroscience is among the most challenging and exciting fields in biomedical research. At no previous time has it been possible to be more optimistic regarding the prospects of basic brain research for advancing our understanding of the human nervous system and thus for furthering our ability to deal with the dehumanizing disorders of the brain. Testimony to this is the remarkable proportion of Nobel Prizes in Physiology or Medicine that have been awarded for neuroscience research over the past two decades.

It was indeed puzzling and dismaying that in the face of such exciting promise the primary source of support for brain research, the NINCDS, underwent serious budget deterioration throught much of the 1970s. It has only been within the past few years that Congressional action has begun correcting this inequity and stabilizing the Institute's budget.

This has contributed enormously to the recent rapid advances in the field and it is essential to maintain this stability if we are to capitalize upon major targets of opportunity that could well contribute significantly to our ability to deal with such disorders as spinal cord injury, multiple sclerosis, amyotrophic lateral sclerosis, severe epilepsy and certain of the senile dementias.

The proposed NINCDS budget of $276.3 million would permit funding of considerably less than one-third of the approved research grants. This would again plunge the brain research community into a despairing period of instability. It is unclear how many of these "starts and stops" can be absorbed without irreversible compromise of the national brain research effort. As individual citizens we enthusiastically support any effort to achieve a healthier national economy, and we certainly appreciate the President's effort to minimize the impact on the NIH of broad reductions in federal spending. However, we fear that the proposed NINCDS budget will seriously undermine the explosive developments in brain research, and the effects of this would be realized for many years in both human suffering and medical costs.

Of particular concern in this regard is the decrease in support for research training in the brain sciences. The reduction in training funds that has occurred since President Johnson's administration has been especially acute at NINCDS, where there has been a decline of 28% in actual dollars since 1973. This is in contrast to other NIH institutes where there has been an average increase of approximately 70% in actual dollars since 1973. The President's budget now requests eliminating yet another $2 million from the NINCDS training budget. A further decrease in training funds at the Institute threatens an incapacitating reduction in the influx of new talent into the field. Training in neuroscience requires at least a 6-year commitment, and the "stranding" of trainess "in the pipeline" threatens the credibility of federal efforts to meet national manpower needs on a rational basis. Will a pool of potential trainees respond the next time we recognize a shortage of brain scientists? Indeed, will the training institutions respond to any federal program requiring a long-term commitment on their part? The decline in neuroscience training support must ultimately compromise the vitality and research capability of the brain sciences; this in turn, must compromise our capability of responding to requests by the Congress for rapid progress in identifying, treating, and preventing major brain disorders.

In sum, when we reduce our basic research capability, from where else will the tools and concepts come with which applied research can dissect the critical clinical problems and reach out for cures and prevention? From where else will the trained researchers come who will be needed to staff the mandated programs in applied research areas? Trained scientists and innovative solutions to gaps in our knowledge do not flow on demand like water from a fountain. Once turned off, the flow of new personnel, ideas and research facilities will be excedingly slow to regain momentum, and the cost will be considerable. In turn, we can anticipate that the success of our colleagues participating in disease-oriented programs may well be substantially below your expectations, because the momentum of scientific advance will have been seriously retarded by the compromise of fundamental neuroscience research.

STATEMENT OF DR. FRANK YATSU, NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS

SUMMARY STATEMENT

Stroke and trauma to the brain and spinal cord are major health problems affecting nearly one million Americans annually. Despite significant inroads in therapy, now available in virtually all major metropolitan centers, stable research support for ongoing basic and clinical investigations is needed to fulfill the goal of maximizing recovery and minimizing suffering. The tangible payoffs will be healthier Americans and reduced costs for health care.

THE PROBLEM

Stroke remains the third major cause of death and disability among American adults with over a quarter million new cases annually and over 2.5 million continuing to suffer its effects. The costs for medical care plus in loss in earnings for a total of over $10 billion annually.

Head and spinal cord injury account for over one-half million new cases annually with another over one million impaired victims suffering its effects. The direct and indirect costs for the medical care exceeds $4 billion a year.

PROGRESS TO DATE

In major medical centers across the county and at the National Institutes of Neurological and Communicative Disorders and Stroke (NINCDS), the Federal Government's support of biomedical research has yielded impressive insights into the prevention, therapy and rehabilitation of stroke and trauma patients.

In stroke research, basic investigations are clarifying the complexities of the stroke mechanisms, separable into those affecting the microcirculation, the blood elements such as platelets and coagulation, brain swelling and the exquisite vulnerability of brain. Promising clues indicate that the disabling effects of strokes can be significantly minimized. Similarly, evidence for risk factors including high blood pressure, diabetes mellitus and heart disease, are becoming more clearly delineated. Rehabilitative measures for relearning of impaired functions, such as speech and dexterity, are also yielding to behavior modification. Basic research on neuroregeneration has potentials in hastening recovery. Advances in noninvasive tests for vascular disease, computerized tomography (CT scans), positron emission transtomography (PET scanning), and microsurgical techniques, such as bypass surgery, also promise to provide important new information on prevention and interventional therapy.

Major advances with head and spinal cord trauma are in the acute care of patients, such as monitoring for increased brain pressure. With appropriate therapies, significantly improved outcome has occurred. Ongoing studies to evaluate the basic mechanisms underlying secondary damage, such as brain swelling, are providing clues that the brain can be normalized.

PROSPECTS FOR THE FUTURE

Two major problems face Stroke and Trauma research: funding level and training. Sophisticated biomedical research is costly due to the requirement for highly trained and skilled personnel and the dependence on expensive technical equipment and supplies. Unchanging appropriation levels will represent a 20% actual dollar reduction and a commensurate decrease in individual research investigators.

The reduction of biomedical research support has already witnessed an alarming shortage of research trainees, and steps must be made to encourage and support a continuing influx of dedicated investigators, a necessary future link and buttress for continuing health care advances.

STATEMENT OF DR. BYRON H. WAKSMAN

Multiple sclerosis (MS) and related diseases affect about 500,000 people in the U.S. alone, and their estimated annual cost to the Nation is more than $3 billion. (Other neurological and communicative disorders affect as many as 50 million Americans -- one out of five -- and cost the country $65 billion annually).

MS is a chronic disease of umpredictable course, often progressing to severe disability, even to death. It begins in people 15 - 55 years of age -- thus it affects both men and women in the prime of life. Since its average duration is 30 years, the impact, both social and economic, is entirely out of proportion to the number of individuals affected. To the loss of manpower is added the devastating effect on families of patients, the cost of hospitalization, the need for special chronic care facilities and for a wide variety of patient services, rehabilitation programs, etc.

There is no hope of eliminating or dealing effectively with MS without basic research to elucidate the mechanism of this disease.

Many great diseases of mankind have been brought under control by continued research over the last 150 years. Beginning with Pasteur's discovery of bacteria in the mid-19th century, diphtheria, pertussis, tetanus, anthrax, typhoid fever, and more recently virus diseases like smallpox, rabies, polio, measles (and now hepatitis) have been largely or entirely eliminated by microbiological, immunological, and pharmacological research leading to development of specific vaccines, and later to antibiotics and chemotherapeutic agents. Early in this century biochemical and nutritional research led to elimination of widespread nutritional diseases such as scurvy, ricketts, and pellagra. The discovery of hormones at about the same time provided means of control for serious endocrine diseases like diabetes and hypothyroidism. Finally we have learned the mechanism of many genetic diseases which can now be treated.

It might be said in complete seriousness that the easy diseases were all worked out in the first 100 years. In every case, adequate means of prevention or treatment were developed only when the basic research in the relevant disciplines had been carried far enough to make this possible.

MS is typical of a large group of diseases which have resisted our research efforts thus far. These affect young people and are manifested by patchy inflammation and destruction of tissue appearing without obvious cause. In MS, the brain and spinal cord are affected. In other instances, other tissues may be attacked, for example the joints in rheumatoid arthritis, a disease affecting a very large numbers of people. All available evidence says that these (and several other diseases showing a pattern of chronic relapsing inflammation and tissue destruction) represent a unique type of immune reaction, perhaps to viral infection.

This group of diseases, together with dementia and other degenerative diseases, atherosclerosis (hardening of the arteries), and cancer will undoubtedly yield to sustained investigations which make use of new concepts and techniques developed in the research of the last decades. In the particular case of MS, recent research in immunology, virology, and cell biology and the application of these to the nervous system promises an early solution.

While continued support of basic research throughout the NIH is essential for solution of these disease problems, research supported by NINCDS is crucial for MS and related diseases of the nervous system. An effective cadre of highly trained scientists and technicians concerned with these diseases and sophisticated in the use of concepts and techniques from many fields has been built up over the past 30 years throughout this country and within NINCDS itself with funds provided by this institute.

This "research machine" is fragile -- short term fluctuations can easily destroy it. Once a scientist working in a complex field like neurobiology or immunology stops for more than a few months, his effectiveness is lost, and he may be unable to start again, even if funds become once more available, and reach his former level of effectiveness. The complex research teams needed to confront the complexity of today's research, also created over a period of years, are also easily destroyed by lapses in funding.

An essential part of the "research machine" is the continued entry of young scientists, trained in new ideas and techniques, who not only replace those who die or retire but also continually move the research process into new areas. Whithout adequate funds for training this process dries up and research does not move. Stability of funding is also required to make a research career attractive to outstanding young people. Major fluctuations in support by Congress will convince such individuals that research is an unreliable career and they will turn elsewhere.

Therefore it is urgent that Congress appropriate sufficient funds:

a) to guarantee stability of the existing research programs supported by NINCDS;

b) to provide for modest growth, which permits rapid application of new concepts and techniques to research on neurological disease;

c) to support the research programs of other institutes of NIH, from which many of these concepts and techniques are derived;

d) to train new scientists at a rate commensurate with modest growth.

STATEMENT OF DR. ROBERT J. RUBEN

The definition of what is human involves the quality of our communication. When the portals and pathways of our communication are blocked and distorted, human life is bitterly diminished. The repercussions of blocking and diminishing of communications are manifold in their effect to both the individual and the society.

One out of ten Americans now suffers from a communicative disorder and one out of four individuals, 65 years or older, has a significant hearing impairment. Before their lives are over, almost all Americans will be afflicted by a serious and incapacitating voice, speech, language or hearing disorder. Collectively, these disorders of voice, speech, language and hearing are called communicative disorders. They affect Americans at all ages from before birth until old age. The impact on the individual is to reduce substantively his or her ability to communicate, to develop intellect, to gain employment, to develop interpersonal relations and to function in our American society. The cost to the individual, to the family and the American society is extremely high. It is known that an excess of $25,000,000,000 is spent, annually, for just the care of the hearing impaired and those with speech disorders. No estimate has been made of the cost of decreased productivity, let alone the qualitative cost of tens of millions of Americans with thwarted lives. There is the opportunity, need and demand to prevent, cure and care for these devastating and costly disorders. I will use just one example from this very broad field of voice, speech, language and deafness to illustrate what can and must be done to better the lives of the American people. Genetic deafness, that is, hearing loss which is inherited, is found at all ages and in all segments of our population. Genetic deafness accounts for at least half of all congenital hearing loss and may be the direct cause or indirect cause of greater than 50% of all hearing losses which occur during the life span of the American population. Genetic hearing loss occurs in an infant, a young child, a teenager, a young adult, a person in the prime of life, and also in our senior population. At the present time, there has been developed, through the basic research funded by the National Institutes of Health and the National Institute of Neurological Communicative Disorders and Stroke, many scientific discoveries which can be utilized to define the basic mechanisms underlying these genetic abnormalities. Some of these advances are the understanding of the genetic code, the ability to grow the inner ear, the physiology and biochemistry of the inner ear, the determination of the genetic map of man and many others.

Unfortunately, the underlying mechanisms of the various types of genetic hearing loss are not known. If they were, then we could either prevent or cure many of these disorders. The situation for genetic deafness is paradoxical when compared to all of the other genetic disorders of man. In each of these others, for example, the central nervous system, bone, blood system and others, there has been and is being developed an understanding of the biochemical basis of the disorder with a resulting methodology for a prevention or cure. Why has this not happened to genetic deafness and also for all of the other genetic communicative disorders? The answer, unfortunately, is that there is an insufficient pool of competent, basic and clinical scientists to carry out the needed work. For example, there are probably no more than two or three human geneticists who work fundamentally in the genetics of human deafness and the genetics of communicative disorders in the entire United States. A similar situation exists in the areas of embryology and biochemistry when applied to genetic deafness. There is an appalling lack of sufficient scientific manpower to even begin to apply the already known knowledge in this area to genetic deafness.

The most crucial aspect of our inability, as a nation, to begin to apply our scientific knowledge to those with hearing impairments is the extremely small number of trained otorhinolaryngologists (ear, nose and throat doctors) who are able to obtain funded research grants from the NINCDS. There were a total of 87 grant applications in the area of communicative disorders submitted to the January, 1981 Council of the NINCDS in the entire area of communicative disorders. Only six of these grants were submitted by principle investigators who were clinical otorhinolaryngologists. Of the six applications, only one was approved and funded. These figures mean that there are entirely too few otolaryngologists who have the training to enable them to submit grants and even fewer who can successfully compete with other investigators to obtain funding. The clinically trained otolaryngologist has unique knowledge of hearing impairment in man. It is only the otolaryngologist who is able to apply the basic science discoveries to the clinical problems. It is also the clinically trained otolaryngologist who will have the background and knowledge to be able to make substantive advances in the area of human deafness. It is apparent that there are too few otolaryngologists who have this unique knowledge who also has the research skills needed to obtain funds to investigate the clinical problems of hearing loss. The number of otolaryngologists submitting and obtaining NINCDS approval and funding has steadily declined over the years. In practical terms, this lack of properly trained clinical otorhinolaryngological investigators means that there will probably be no, or very little, advance in the field of deafness. The need to train clinical otorhinolaryngologists who are also clinical investigators is an imperative and urgent need if there is to be any progress in the areas of human impairment. This need can only be met by the allocation of substancial funding for the programs for the scientific training of clinical investigators in the area of otorhinolaryngology. Without this funding, the great discoveries in basic science will not be applied to the hearing impaired citizens in the United States.

Although there is the opportunity for prevention and cure, we, the American society, still have tens of millions of our citizens afflicted with communicative disorders and it is our obligation to care for our fellow countrymen. The level of care which is possible, as has been demonstrated in either model systems in the United States or in the Western European countries, can greatly ameliorate the handicap of these individuals. Unfortunately, we are not able to deliver this level of care to our citizens because of severe financial restrictions. Additionally, there is a pressing need to evaluate the effectiveness of our care and to develop improved methods of care which would result in a more cost effective system of care then we now have. This type of clinical research is needed and there is the pressing urgency to provide funding so that this can be done to improve the lives of this very large segment of the American people.

STATEMENT OF DR. HARTWELL G. THOMPSON

Mr. Chairman, thank you for inviting me. My name is Dr. Hartwell G. Thompson. I am a Professor and the Head of the Department of Neurology at the University of Connecticut Health Center in Farmington, Connecticut.

Mr. Chairman, in this section I wish to cover some of the extraordinarily important areas which are considered under the domain of the neurological disorders branch of the National Institute of Neurological and Communicative Disorders and Stroke. You have had or will have from previous witnesses documentation of the importance of continuing the work in stroke and trauma, the basic neurological sciences and communicative disorders.

The neurological disorders branch of NINCDS covers a wide range of illnesses that have an extraordinary epidemiological impact on the nation, which causes vast loss in productivity including earning power, quality of life, and leadership for our nation. If I may, Mr. Chairman, allow me to stress some of these things that effect both the beginnings of life and the later stages of life.

Some Examples of Accelerated Aging

In the later stages of life we recognize that all of us are mortal but would like to do all that we can to keep the brain and its extensions healthy so that all of us (if I may use an aphorism) may die young and as late as possible. There are three or four striking illnesses which cut men and women down in the prime of life in many cases. These are Alzheimer's disease, an illness which used to be called presenile dementia; Parkinson's disease, first described in 1817 by a British apothecary and surgeon as the shaking palsy; Huntington's disease, well known to you because of the pioneering work done by the organization committed to this and because the Congress has indicated a special need for study in this area. (I might add this is sometimes called Woody Guthrie's disease since he had this illness.) Finally, amyotrophic lateral sclerosis which is sometimes called Lou Gehrig's disease after the famous "iron horse" of the New York Yankees who played first base with such distinction for so many years in the halcyon days of that baseball team. This disease, ALS, is often referred to as motorneuron disease because there are many variations.

The point I should make is that in the instance of Parkinson's disease, men and women frequently are afflicted with this before they are 65 or 70 and it not only causes disability due to impaired movement, such as awkwardness of movement, slowing down, difficulty in turning, but also problems with coordination due to the rythmical tremor which I am sure many of you have noted in patients so afflicted. One of the more important aspects, however, is the fact that people with Parkinson's disease often, but not always, lose a lot of their drive and energy, are subject to unexplained depression which can be extraordinarily enervating and debilitating for them, and they lose, after a period of time, some judgment capacity, even with the use of the most effective pharmacological agents available at this time. These people who may be at the peak of their careers as executives, physicians, lawyers, and in other walks of life, should be helped by more effective pharmacological agents and a better understanding of the causes so that the waste of their talents will not occur.

Amyotrophic lateral sclerosis or motorneuron disease is an illness which is one of the most difficult and heart rending that neurologists take care of. These are men and women who are usually cut down in the prime of their life. It is slightly more prominent in men than in women but there may be a few exceptions to this and there may be a few areas where it is more prevalent than in others. For example, one area of Finland and another area of Japan and so on. The illness is not normally hereditary although there are familial forms. There is an extraordinary collection of people in Guam who have a variation of this illness. It has been estimated that the incidence is about one new case per 100,000 of population per year with a prevalence of five per 100,000. I have a heart breaking case that I am now caring for who is a 42-year-old executive in a prominent industry in central Connecticut, who in a setting of otherwise perfect health, has gone from full employment, carrying out major decision making for a huge company, to virtually total dependence on his wife and others who help support the family and care for the many needs that this man can no longer take care of since he is barely able to walk, has no use of his arms and will soon be unable to swallow. This is a great need and it is an area in which basic research should be stressed because the various clinical leads which might be pursued are not nearly as prominent or as promising to pursue as, for example. would be the case in cerebrovascular disease, cancer of the brain and other cancers, nutritional disorders, all of which are important but in which there are many important leads being pursued.

Huntington's disease should be stressed again. There has been a commission appointed which reviewed the topic quite thoroughly but, like all of these commissions whether they be the Huntington Commission or the others, they all have come back to the same point as would be true if any additional presidential commissions were made: There is a great need to get on with our basic science research, transfer the fruits of the laboratory to the clinical areas by means of having adequate support for well-trained clinical investigators and basic science investigators.

Huntington's disease, amyotrophic lateral sclerosis, Parkinson's disease, and Alzheimer's disease all probably represent accelerated aging, effecting related components of systems of the central nervous system. We know not nearly enough about these things and the cost to the nation is prodigious. The average patient with Huntington's disease has it for 15 years, probably needs to have custodial care in a nursing home for five to seven years. At the present rate of $50 a day or more per patient per day in a skilled nursing facility (the going rate in many areas of the country), this translates into an almost incomprehensible catastrophe to the families and to society. Even in the illness of shorter duration, such as amyotrophic lateral sclerosis, you can easily see the cost in not learning more of the cause, prevention and care of these patients.

Poorly Understood Afflictions of Infants

I should like to take a few moments to address the other end of the spectrum, that is the damages to the nervous system which occur at the moment of birth or with premature birth. As the technological advances have progressed to previously unimagined sophistication, more and more children born prematurely are surviving. It has been learned in the process of this that various organ systems are unable to function normally in the development of the body, in general, and the brain, in particular. Now that we have the advantages of computerized tomography scanning, the incidence of intraventricular hemorrhage or brain hemorrhage of one sort or another in infants born at ages younger than 36 weeks gestation has been revealed to be extraordinarily high compared to pregnancies of 40 weeks. We need to know more about what causes these hemorrhages, the general ones as well as the unusual illness referred to as periventricular leukomalacia or a softening around the corridors or pockets in the brain that normally carry central structures and cerebrospinal fluid. We also need to know more about the ways of predicting and preventing hypoxia or a lack of the normal oxygen supply during normal parturition or in the later stages of pregnancy.

Environmental Factors

One other area that should be emphasized is the effect of the environment on brain health and development. We know much too little about the effect of trace metals or elements normally found in small amounts and not thought to be toxic such as aluminum, manganese, copper and various others. This has been an under-funded and under-recognized area. The effects on the brain of industrial pollution of the nation's underground water (aquifers) with substances such as tri-chlor-ethane and tetra-chlor-ethylene and many other dangerous substances is just beginning to be appreciated.

In summary, we believe an investment in the brain is the best investment that society can make. While not meaning to underrate or downplay investigations in other medical or health problems, it makes little sense to go to heroic measures to deal with vascular disease, pulmonary problems, and metabolic problems if there is not a normal brain and spinal cord, hearing and visual apparatus, and neuromuscular apparatus to utilize improved or corrected vascular, pulmonary, and metabolic functions. The brain that can't think even when it is supplied with optimal nutrition is a lost brain and lost brain power handicaps our nation and weakens the fabric of our society, both in terms of productivity and the quality of life. Thank you for your attention.

STATEMENT OF DR. JAMES B. WYNGAARDEN, PROFESSOR AND CHAIRMAN, ASSOCIATION OF PROFESSORS OF MEDICINE

Senator RUDMAN. We are now going to hear from three witnesses in the area of general medical science. Dr. James B. Wyngaarden, representing the Association of Professors of Medicine; Dr. Peyton E. Weary, will speak on behalf of the American Academy of Dermatology; and Dr. John Cooper will testify as President of the Association of American Medical Colleges. Would anybody like to lead off or go left to right?

Dr. WYNGAARDEN. I am Dr. Wyngaarden. I am appearing this morning on behalf of the Association of Professors of Medicine, the organization that represents the chairmen of departments of internal medicine in 125 U.S. medical schools.

As chairmen of these departments, we have direct responsibility for 60 to 70 percent of the teaching of all medical students in our schools, a substantial portion of the patient care delivered in the United States and the majority of the extramural clinical research conducted under the aegis of the NIH.

It is this last portion of our responsibility that I want to discuss this morning. The members of APM are physician scientists. Virtually all of us had substantial research involvements early in our careers and remained deeply committed to biomedical research.

I would like to review briefly the evidence that the United States will soon be facing a critical shortage of physician scientists. First, in 1966–68 there were about 4,100 physicians in the pool of biomedical research trainees. The number of physicians in that same pool has averaged about 1,900 since 1976.

Second, in 1963, 49 percent of the students graduating from the Harvard Medical School expressed a serious interest in research. By 1976 this figure had fallen to 2 percent.

In 1966, 45 percent of all new research projects awarded by NIH were submitted by medical doctors as principal investigators.

Since 1975 this figure has averaged about 25 percent.

The reasons for this decline are complex, but the consequences are easily identified by biomedical research and the transfer of research will be crippled if this trend continues.

After examining the new administration's budget proposals, we are gravely concerned that not only will these trends continue but that they will worsen. In our opinion, the key aspect of the budget proposal that is most destructive is the reduced funding for research training.

It is our understanding that a rescission of $62 million has been requested from the fiscal year 1981 training budget and further, that the funding level proposed for research training in fiscal 1982 is $132 million, which is $56 million less than the current training. We also understand the President proposed to reduce the total number of trainees by 7 percent, to eliminate the institutional allowances for the training and to suspend reimbursement of indirect costs associated with the training.

We believe all three of these are seriously flawed. If the total number of trainees is reduced from 10,700 in 1980 to 10,000 in 1981 and 1982, we would fall far short of the recommendations of the National Academy of Sciences that NIH should be training at least 10,975 researchers per year, thus the proposed training effort would be inade-quate. The other two aspects of the administration's plan to cut the research training budget are more complicated and embody erroneous assumptions and dangerous implications.

First, the institutional allowance question. The administration proposes to eliminate the payments made to institutions that provide the facilities and environment in which training is conducted. They suggest that the institutions which have built training environments of unparalleled excellence should receive only funds to cover tuition expenses.

For the past 30 years the Government has provided institutional allowances paying for faculty time, visiting scientists, and supplies essential to the training program. The Government status of the program, it acknowledged Federal responsibility for training biomedical scientists. A responsibility this administration agrees is appropriate and necessary.

But the Government also took the concomitant responsibility of the——

Senator RUDMAN. Let me interrupt you one moment. How much more time will you need to finish that statement?

Dr. WYNGAARDEN. One more page. The institutional allowances that goes into the training grant to insure quality, continuity, and stability of strong institutional environment. The institutions that have trained our scientists have weakened the program for savings that would be minuscule.

The Federal Government has for years recognized the legitimacy of indirect costs associated with research training. The new administration is planning to suspend those reimbursements, such as heating and library services. Inherent in this proposal is the concept that institutions should be able to underwrite the sizable indirect costs associated with this effort. I would argue the administration's confidence that institutions can and will increase the cost sharing is ill-founded and many outstanding programs will collapse because institutions are being pulled apart at the seams and fiscal pressures cannot commit any more money maintaining research to the environment. The Association of Professors of Medicine strongly urges this committee to consider the consequences of cutting this research. In order to continue research, the $62 million rescission must not be approved and these funding levels would prevent the demise of training programs and would support approximately 10,500 trainees, still a slight reduction from the 1980 total and 500 below the academy minimum.

If the administration's proposal is accepted, we, as a Nation, stand to lose in future knowledge and reduction and cure of disease is, of course, incalculable.

Senator RUDMAN. Thank you very much.

STATEMENT OF DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. COOPER. The Association of American Medical Colleges appreciates this opportunity to submit its views on the fiscal year 1981 rescission request. The association members have a direct and deep involvement in many of the programs being reviewed by this subcommittee.

At the outset, I would like to state that the AAMC endorses the testimony on the health budget presented by the Coalition for Health Funding, of which the AAMC is a founding member. The association places its highest priority on funding for the National Institutes of Health. There is no other comparable source of funding available in the private sector to maintain this very valuable resource which has been developed over a period of three decades.

We urge Congress to continue its long traditional commitment, to further biomedical research enterprise and follow last year's precedent by disapproving the administration's rescission request and increasing support for NIH's programs.

Ostensibly, the President's recommended budget for fiscal years 1981 and 1982 encourages modest growth for the NIH. However, if the President's fiscal year 1982 budget and fiscal year 1981 rescissions are accepted, the level of effort supported by the NIH research will be reduced by almost 10 percent below the fiscal year 1980 level.

We endorse the testimony on research training by Dr. Wyngaarden. Training bright young physicians and basic scientists is critical to continuation of our biomedical research effort.

Among the other programs for which increased support is vital, are important issues such as the biomedical research training. These grants stabilize the research programs and the research intensive institutions. The proposed rescission of $1.6 million will impair the academic performance in the NIH ambits to maintain their institutional integrity.

The National Library of Medicine is important because the effective utilization of high technology is a hallmark of this important program that backstops the entire research enterprise.

The AAMC recommends a fiscal year 1982 appropriation of $53 million for the NIH and urges that it be spared the $341,000 rescission requested by the administration.

The association recommends that training programs be funded at $398 million in fiscal year 1982. The recommended fiscal year 1981 rescissions and minuscule fiscal year 1982 budget would bring ADAMHA's budget to a standstill, virtually precluding research for new projects.

We also urge support for new research which is essentially eliminated. Continuing the exciting advances made, will be, at a time when we are at a threshhold of new discoveries which may dwarf the benefits accrued to our people by the psychotropic drugs, which was used a few years ago.

The National Center for Health Care represents our only national resource for focusing and studying research which is essential. The association, therefor, recommends a fiscal year 1982 appropriation of $84.8 million. The Health Resources and Services Administrations are responsible for three basic forms of aid essential to the continuance of the sustained excellence of medical education for which the company has become renowned: student systems, institutional support.

We urge that the subcommittee not accept the request of the administration to rescind funds for support and health profession student loans appropriated after long and vigorous debate in this House last year. Student assistance is critical if we are not to have medical professions restricted to children of high-income families.

Therefore, we recommend $18 million be appropriated for the financial needs scholarship program and $25 million for the helping student loan program and $12 million for the loan program.

The special health training programs, we think, are very important. These are special projects and we would call particular attention to the importance of meeting national goals of adequate funding and primary care program, training programs and general internal medicine, family medicine, and area health education centers.

We also would hope that Congress would continue institutional support for medical schools. This is absolutely necessary for the stabilization of an institution's entire educational program. The value of these funds to the institutions in maintaining their opportunities for innovation, far exceed the level of these fundings. The association continues to believe that the current national economic picture demands fiscal approval, but it is also convinced that for the truly modest investment for health education and research program, the Nation will receive an incalculable benefit.

STATEMENT OF DR. PEYTON E. WEARY, CHAIRMAN, COUNCIL ON GOVERNMENTAL LIAISON, AMERICAN ACADEMY OF DERMATOLOGY

Dr. WEARY. I am Dr. Peyton Weary, chairman of the department of dermatology at the University of Virginia Institute of Medicine and chairman of the American Liaison of Dermatology. I am presenting this on the behalf of the Society for Investigative Dermatology. Our interest spans those of the number of Institutes within NIH and also National Institute of Occupational Safety and Health.

I will not read the testimony which I have submitted to you. I think it stands by itself. But I would like to mention a few things.

I indicated in my testimony several of the important new advances on research in skin diseases. We are very encouraged at this time by the positive attitude of the Congress and the administration about the report on research use and priorities submitted to the Congress last year, and we feel that we have a good game plan. That it is well thought out, and it now remains for us to proceed along in an orderly fashion to develop the type of appropriate research activities which will lead us to be able to answer the problems that require answering.

We are particularly encouraged by the unprecedented response which was generated by the Congress support of availability of additional funds for occupational skin disease research. Over 30 research grant proposals were generated by the $2 million commitment, and to date there are eight approved but funded plans, and six approved but unfunded plans. Because occupational skin disease effects such a large segment of the work percentage, 25 percent of the time lost from work is due to occupational disease, we have requested additional support for this high-priority effort.

We share the concerns expressed by others at this hearing that research training and career development support be retained in the face of high budgetary restrictions. This is particularly so for dermatology, which has long been hampered by relative paucity of skilled young investigators. Thank you very much. I will be glad to answer any questions you have about the testimony.

Senator SCHMITT. Thank you gentlemen. I am sorry I have been detained. Let me ask you one question.

Do you feel that the orientation of general medical activity toward rural communities is sufficient today? Particularly in terms of the training and personnel?

Dr. COOPER. I think that there has been a fantastic change in the geographic distribution of physicians. A Rand report shows that towns below 10,000, a high percentage of the towns below 10,000, now have very certified specialists in internal medicine, pediatrics, surgery, OBGYN.

It is clear that we are beginning to see a great movement of physicians into the rural and underserved areas. It is predicted by studies made by the Robert Wood Johnson Foundation that there will be adequate access of all of [illegible] percent of our citizens to primary care, continuing care, by the year of [illegible]. Now it is over 80 percent.

Senator SCHMITT. One of [illegible] problems has been the specialty of internists, internal medicine. Have [illegible] individuals specialized in that area found incentives to go into rural practice?

Dr. COOPER. They are moving, as the Rand study shows, and the Robert Wood Johnson study shows.

Senator SCHMITT. Are you familiar with the University of New Mexico rural primary care?

Dr. COOPER. Yes, I am a New Mexican, too. And I keep close contact with that. They have done a tremendous job in improving distribution of physicians in New Mexico.

Senator SCHMITT. There is an interesting new approach to medical education involving work experience within the rural areas as a major part of the curriculum. We have great hopes for that program. We hope it will add to the progress.

Dr. COOPER. May I ask that a slightly longer statement than my oral statement be incorporated?

Senator SCHMITT. Yes; we would appreciate that very much. Sorry the time is so limited today.

[The statements follow:]

STATEMENT OF DR. JAMES B. WYNGAARDEN

This testimony is on behalf of the Association of Professors of Medicine, the organization that represents the Chairmen of Departments of Internal Medicine in the 125 U.S. medical schools. As chairmen of these departments, we have direct responsibility for: 60-70% of the teaching of all medical students in our schools; a substantial portion of the patient care delivered in the United States; and the majority of the extramural clinical research conducted under the aegis of the National Institutes of Health. It is this last portion of our day-to-day responsibilities that I want to discuss today.

The members of APM are physician scientists; virtually all of us had substantial research involvement early in our careers. Because of this personal involvement and because of our current responsibilities, we are individually and collectively committed in a deep sense to biomedical research.

Although we have spoken to this Committee before about the very disturbing trends in clinical research manpower, I would like to briefly review the well-documented evidence that the U.S. will soon be facing a critical shortage of physician scientists:

- In academic years 1966-67 through 1968-69, there were an average of 4089 physicians in the pool of biomedical research trainees. The number of physicians in that same pool had fallen to about 2,570 by 1975 and has averaged about 1,900 since 1976.
- In 1963, 49% of the students graduating from the Harvard Medical School expressed a serious interest in research; by 1976 this had fallen to 2%.
- In FY 1966, 45% of all new research projects awarded by NIH were submitted by principal investigators who held an M.D. degree. Since 1975, this figure has averaged about 25%.

The reasons for this decline are multiple and complex, but the consequences are easily identified and straightforward: the conduct of biomedical research and the transfer of research results to patient care will be crippled if this trend continues.

After examining the new Administration's budget proposals, we are gravely concerned that not only will these trends continue but that they will worsen. In our opinion, the key aspect of the President's proposals that will be most destructive to the nation's current and future biomedical research efforts is funding for research training.

Based on figures revealed to date by the Administration, it is our understanding that (1) a rescission of $62 million has been requested from the FY1981 training budget and (2) the funding level proposed for research training in FY1982 is $132 million--$56 million less than the training budget provided by the current continuing resolution. It is also our understanding that the President proposes to reduce the total number of trainees by 7%, to eliminate the institutional allowances that are paid to schools that provide the training, and to suspend reimbursement of the indirect costs associated with training programs.

We believe that all three of these proposals are seriously flawed and would be highly destructive.

If the total number of trainees is reduced from 10,700 in 1980 to approximately 10,000 in 1981 and 1982, we would fall far short of the recommendations of the National Academy of Sciences that NIH should be training at least 10,975 researchers per year. So in terms of sheer numbers of future biomedical investigators, our proposed training effort would be inadequate.

The other two aspects of the Administration's plan to cut the research training budget are more complicated and embody erroneous assumptions and dangerous implications.

Institutional Allowances

The Administration proposed to eliminate the payments made to institutions that provide the facilities and the environment in which training is conducted. They suggest that the institutions--which have built laboratories and training environments of unparalled excellence--should receive only funds to cover tuition expenses. For the past thirty years, the government has provided institutional allowances for faculty time, visiting scientists, and supplies essential to the training program based on the sound notion that training cannot be conducted in a vacuum and that these obviously superb programs that have trained many of the best scientists in the world deserve a modest amount of Federal support. When the government established the research training program, it acknowledged a Federal responsibility for training biomedical scientists--a responsibility the current Administration agrees is appropriate and necessary. But when the program was established, the government accepted the concomitant responsibility for the quality as well as the quantity of the biomedical manpower pool. The institutional allowances were built into the training grants to ensure quality, continuity, and stability of strong institutional environments. No one could argue that the pay-off for institutional allowances has not been impressive. Pulling the rug out from under the institutions that have slowly and carefully built rich environments for the training of future medical scientists would seriously weaken the program for a savings that would be miniscule in terms of the entire Federal health budget.

Indirect Cost Reduction

The Federal government has for some time recognized the legitimacy of reimbursing a portion of the indirect costs associated with research training. The new Administration is proposing that the training institutions not be reimbursed for such training-related expenses as heating, lighting, and library services. Inherent in this proposal is the concept that the institutions are the benefactors of the national training effort and that they should be willing to underwrite the sizeable indirect costs associated with this effort. It is true that some rather abstract benefits accrue to the institutions that train future Nobel Prize winners and that produce future scientists dedicated to the search for new knowledge to treat and cure human disease. But to a much greater extent, the benefits of the research training effort accrue to the people of this country. The decreasing morbidity and mortality rates associated with such major diseases as cancer, stroke, and hypertension make this profoundly obvious. I would argue that the Administration's confidence that institutions can and will increase their cost-sharing is ill-founded. Many outstanding programs will collapse because institutions--that are being pulled apart at the seams by mounting fiscal pressure and frustrating efforts to meet a host of other important national priorities--cannot and will not commit more money to maintaining a research training environment.

The APM strongly urges this Committee to consider the consequences of the proposed cuts in research training very carefully. In order to maintain a stable research training effort, the $62 million rescissions of the FY1981 training budget must not be approved and the FY1982 level should be set no lower than $190 million. Funding at these levels would prevent the demise of training programs and would support approximately 10,500 trainees--a slight reduction from 1980 and 500 below the National Academy of Sciences minimal goal.

If the Administration's proposal is accepted, the Federal government stands to save 2 hundredths of 1% of the Federal health budget. What we as a nation stand to lose in future knowledge to reduce suffering and cure disease is incalculable.

STATEMENT OF DR. JOHN A. D. COOPER

The Association of American Medical Colleges (AAMC) appreciates this opportunity to submit its views on the President's FY 1982 budget, and FY 1981 rescission requests for the health programs of the Department of Health and Human Services (HHS).

Since its founding in 1876, the Association has steadily expanded its horizons so that today it represents the whole complex of individual organizations and institutions charged with the undergraduate and graduate education of physicians. It serves as a national voice for 126 accredited medical schools and their students; more than 400 of the major teaching hospitals in the United States; and over 70 academic and professional societies whose members are engaged in medical school teaching, patient care and biomedical research.

The position of the AAMC on the President's health budget as a whole has been embodied in the testimony and supporting documents of the Coalition for Health Funding, presented to the Subcommittee on March 17, 1981. We strongly support these recommendations.

The areas of fundamental concern to the AAMC include the health manpower training programs funded under the auspices of the Health Resources and Services Administrations, the National Institutes of Health, research and training initiatives at the Alcohol, Drug Abuse and Mental Health Administration and those centers whose programs operate under the Office of the Assistant Secretary for Health concerned with health statistics, health services research, and health care technology assessment.

This year, unlike any other year in recent memory, the concern of the nation and the Congress is almost exclusively focused on restoring the health of our economy. In this context, the President has called upon all of us to make sacrifices. However, some of these well intentioned proposals have seemingly been translated into wholesale reductions of programs, especially health initiatives, that have lost sight of the importance of Federal investment in these areas.

The Association implores the Congress to weigh carefully the short and long-range consequences the proposed retrenchment in funding discretionary health programs portends. Many of these such as the National Institutes of Health have no counterpart or other source from which to derive revenue; thus, absent Federal support, they would not survive.

Health Resources Administration and Health Systems Administration: Health Manpower Programs

The Health Resources Administration (HRA) is responsible for administering three basic forms of aid which are essential to the continuance of the sustained excellence of medical education for which this country has become renowned---student assistance, institutional support and special project grants. The AAMC believes that Federal participation in these programs represents an appropriate as well as an important utilization of Federal resources because: the quality of health care received by the people of this Nation is ultimately dependent upon the quality of the education received by medical students; past Government investment in these educational programs has confirmed their value as instruments of change in the immediate and long range implementation of national health policy. This valuable function should not be abandoned.

Adequate appropriations for very basic health manpower programs supported by HRA are now more necessary than ever; medical schools and affiliated teaching hospitals will, in the next few years, be faced with unprecedented financial stresses, some of which could compromise the very existence of some of these institutions. Our institutions are dependent upon an interweaving of many diverse sources of revenue, many of which are insecure. The loss of any one or group of these can not necessarily be made up by others.

The statutory authority for these programs expired at the end of Fiscal Year 1980; these programs are now being funded under the Continuing Resolution and the newly formed authorizing committees have just initiated debate on the issues involved in renewal of this statute. Until the responsible committees have had the opportunity to fully consider the renewal legislation, the AAMC believes it would be both precipitous and an unjustified intrusion into the jurisdiction of the responsible committees for the other Committees to take steps that would undermine these programs. Thus, the Association strongly urges that the Subcommittee not accept the requests of both the former and present Administrations to rescind funds for institutional support, Health Professions Student Loans (HPSL) Program, NHSC Scholarship Program and special project grants. The AAMC believes that until new legislation is enacted, it has no choice but to recommend that the Congress continue funding these programs at their current level, with one exception---the HPSL Loan Repayment Program. Moreover, the Association believes that it is imperative that the Congress provide adequate program support, funds and staff for these programs and urges that appropriations be continued at the current level in order to ensure that these programs are properly administered.

Student Assistance

The Association is of the firm belief that in view of their high income potential, all but the most disadvantaged students should ultimately bear the responsibility for

financing a significant portion of their medical education. However, the cost of obtaining a medical education is becoming almost prohibitive for the average individual. Absent the availability of a reasonably comprehensive portfolio of aid programs, the opportunity to secure an M.D. degree will be limited to only the affluent.

Therefore, the Association views the adequate funding of the student aid programs supported by HRA to be one of its highest priorities and strongly recommends that: $10 million be appropriated for the Exceptional Financial Need (EFN) Scholarship Program; an appropriation of $16.5 million be provided for the Health Professions Student Loan (HPSL) Program and $4 million for its accompanying loan repayment program. The AAMC supports the $4 million figure in the President's budget which is $2.5 million above the current appropriation because it has become convinced that loan forgiveness is a cost-effective mechanism for ameliorating the Nation's geographic and specialty maldistribution problems.

The Association also recommends that hasty action not be taken with regard to the National Health Service Corps Scholarship Program. While the AAMC shares the emerging and growing concerns about this program, the future of this program is presently being debated by the responsible committees. Pending the outcome of this discussion the Association supports the recommendation of the CHF that this program be funded at its current appropriation level of $79.5 million.

Special Health Education Training Programs

These programs have succeeded in complementing in very important ways other mechanisms of support to medical education. While the Association supports the recommendations of the CHF for these programs, there are several whose proven contributions merit particular attention: primary care and family medicine programs; training programs in general internal medicine and pediatrics; area health education centers; and manpower supply and distribution reports.

Institutional Support

The AAMC's views on institutional support are well known. Institutional support is utilized for the stabilization of an institution's entire education program, through discretionary interventions at appropriate times and places. These funds, limited as they are, are the only accessible uncommitted money available to many schools to meet a wide variety of pressing needs. The true value of these funds exceeds, by far, their actual magnitude. Therefore, the Association strongly suggests that this program be funded at least at its present level.

National Institutes of Health

The National Institutes of Health have been phenomenally successful in discharging the responsibilities assigned them by this Nation to advance knowledge in the biological and medical sciences and to prevent and cure human disease. Under the aegis of the NIH: American scientists have emerged as the undisputed leaders in what has been a veritable revolution in the biomedical sciences; a large number of magnificent university research centers have been created; progress in the understanding, treatment and prevention of disease has been remarkable.

Despite this unparalleled record of scientific achievement the Administration has gone on record as recommending only "modest growth" for the NIH. However, the levels it has recommended for FY 1981-82 do not represent growth rather they signify retrenchment that will have an adverse impact upon the biomedical research being conducted at academic institutions throughout our nation. In addition, describing the FY 1981 proposal as modest growth belies the fact that it embodies a mere 2.6 percent increase above the FY 1980 appropriation in a year in which the Consumer Price Index is optimistically predicted to climb to 11.1 percent. Moreover, the Administration's recommendations for FY 1982 of $3.762 billion is only a 7.1 percent increase above the revised FY 1981 request and is again well below the *estimated* CPI for FY 1982 of 8.3 percent.

Even were there no inflation, increased investment in the scientific enterprise is necessary just to stay even. And,the fact remains that research today is an extraordinarily complex undertaking dependent on exquisitely trained scientists, expensive instrumentation, costly reagents, high-priced resources and expensive modern facilities. Thus, despite good intentions, the Administration's proposals will entail substantial reductions in the NIH's buying power rather than any sort of modest gain.

It is especially noteworthy, that both the FY 1981 and the 1982 NIH budget proposals assume enactment of the $27 million pay supplemental request currently before this Subcommittee for consideration. Pending approval of this supplemental request NIH programs are being forced to absorb this reduction as the pay increases which went into effect last October are automatic and not subject to renegotiation. Thus, failure on the part of the Congress to act favorably on the supplemental funds would severely compound the magnitude of any enacted rescissions.

It is the AAMC's conviction that the scope and magnitude of the rescission requests now before your subcommittee represent an implicit assumption on the part of this Administration that the nation's citizens are prepared to take a significant step backward in terms of science's heretofore unrelenting attack on disease and disability. The Association rejects this assumption. It urges the Congress to deny the Administration's request and provide for real growth in the institutes in FY 1982 with an appropriation of $4,008,446,000. At this juncture in order to better illustrate the deleterious affect the proposed rescissions and corresponding FY 1982 reductions would have on the rest, a few of its most important programs have been highlighted.

Research Training

The President's FY 1982 budget request for funds to support the National Research Service Awards (NRSA's) is $133,786 million, $55 million less than the amount available in FY 1981; in addition, the level proposed for FY 1981, after rescission, is $126,898 million, $62 million less than the current level. The bulk of this request is for programs administered by the NIH, lesser amounts are for those of the ADAMHA (NIHM, NIDA and NIAAA) as well as for other components of the Public Health Service.

Expurgation of training for research from the portfolio of Federal programs has become a prime target of the OMB---consistently frustrated by the Congress---since the late 1960's.

This nation has mounted a program of research in the biomedical sciences that is the envy of the world. The yield has been breathtaking. Enormous strides have been made in unlocking nature's secrets. A veritable revolution has been wrought in the biological sciences. Medical sciences have been transformed. A welter of applications have been made to human disease, with spectacular reductions in morbidity and mortality across a broad spectrum of problems. Without scientists of rare and unusual talent, these accomplishments would not have occurred. And without the NRSA's and their antecedent training and fellowship programs, scientists of this mettle and in those numbers would never have been produced. A research program is no better than the scientists who conduct it. If the nation wants a first rate research program, it must include, as an integral cost, the training of the manpower for it.

What does the President propose? He wishes: to reduce by 5% the total number of trainees; to deny the schools engaged in training the institutional allowances paid them in the past; and to suspend reimbursement of the already limited indirect costs associated with training. Let us examine each of these proposals:

- Numbers. All available evidence suggest that the nation is training too few scientists for a research endeavor such as exists in the U.S.A. The future of the nation's very substantial investment in research, made over almost four decades, is endangered whenever the number and the excellence of the research work force falls below par. The Association views the proposed reduction of 500 training opportunities for aspirant scientists as a grave error in judgment.

- Institutional Allowances. The President proposes to eliminate allowances to performer institutions under NRSA instruments (grants to institutions and fellowships to individuals) of training, premised on the proposition that government-sponsored students should not pay more than any other student. When the need for trained scientific manpower became undeniable, the NIH sought to build training environments of high excellence, in which young men and women could be provided unparalleled opportunities for developing their talents for careers in the public enterprise of research. For thirty years, the institutional components of training awards have built and sustained superb departments all across the land. The evidence that these institutional investments paid off is overwhelming. Equally clear is the fact that without them, the quality of training will suffer grieviously at a time when the increasing complexity of science places even more demands on excellence in training programs.

The putative rationale for this action---that the schools are charging the government more than they charge non-government sponsored students---can only be described as pusillanimous. The goal of the government is to develop scientists up to the extraordinarily complex challenges of preventing and curing dreaded diseases. What matter it, if a few of the students in the program only pay conventional tuition. Can't the accountants see that it is equally to the advantage of the government that these students too profit from the excellence of the programs? After all, where else will most of the so-called "free loaders" spend their working careers, other than in the Federally-funded national research enterprise?

- Indirect Cost Reduction. The President's budget proposes to "stretch" the limited funds requested for training by not reimbursing for the indirect costs of research training projects. The principal elements in indirect costs include those for heating, air-conditioning, lighting, power, and library services. Can the legitimacy of these be in doubt. The Administration has essentially thrown the burden back on the schools, mandating that these institutions increase their cost sharing, i.e., increase their subsidization of the Federal Government.

The AAMC views this move as unjust and self-defeating. The research effort of the USA in 1981 is a public enterprise, a long term investment in funding, through research, ways of preventing, of ameliorating and of reversing the impact of the diseases and disabilities that sicken, age, enfeeble, plague and kill our citizens. Investments of the magnitude required are beyond the capability or the feasibility or the will of the private sector. The proposed budget adjustment forces schools to expand endowment from their already substantial cost sharing, at the expense of many other pressing institutional eds. Thus, the Association's charges that this proposal is unjust. Since many institutions either can't, because they don't have the money, or won't because of other priorities, increase cost sharing, many may reluctantly drop out of the program, and splendid training environments, will collapse. Thus, the proposal is plainly self-defeating.

The AAMC is strongly persuaded that it is in the best interest of the country to sustain, at levels recommended by the National Academy of Science, the nation's programs for developing coming generations of biomedical scientific investigators. Arbitrary and ill informed actions such as interdiction of indirect cost reimbursement and of institutional allowances have no place in a task that seeks to do the least possible damage to the vigor, excellence and balance of the spectacularly successful biomedical research apparatus that this nation has created.

Research Grants

Grants for health-related research projects or activities make up the largest category of funding for the NIH. Since the faculties of the nation's medical schools conduct about half of all NIH-funded biomedical research,reductions in this category have a profound effect on the level of research activity being performed at these institutions.

It is with the utmost concern, therefore, that we view the current rescission proposals and recommended budget level of FY 1982. The importance of an increased level of support for competing research projects---the bedrock on which the NIH research programs are based---cannot be overemphasized. Yet, the proposals advanced by the President---$21.8 million be rescinded in FY 1981 and $1.8 billion or an 8.2 percent increase above the revised FY 1981 level be approved for FY 1982---would result in significant reductions in the number of grants funded.

Estimates are that the number of grants funded in FY 1981 would fall by 4.1 percent below the 5,000 base Congress explicitly established just last year as a minimal acceptable level for project grant activity. Moreover, the proposed reduction in FY 1982 which represents a continuation of this pattern exacerbates this loss and sigificantly diminishes the level of biomedical research being conducted in our nation's premier academic institutions.

The magnitude of the proposed reductions does not adequately reflect its true impact on grant activity. Specifically, it fails to portray the fact that such a constriction in the pool of available funds inevitably results in both fewer and smaller grant awards. The NIH has fallen behind in terms of buying power while the complexity and thus cost of biomedical research has virtually skyrocketed. This is due in large measure to unprecedented technological innovation and the need for increasingly sophisticated materials and facilities ---the cost of which has been greatly amplified by double-digit inflation. The upshot is of course, that the individual grant awards have to be larger if the sponsored scientist is to have the instruments and facilities that are required to execute the approved experimental design.

Funding reductions in the amounts proposed would take a significant toll on the average amount to be allotted for individual grant awards as well as the aggregate number of such awards and will inevitably preclude funding some of the most promising, yet expensive research.

Biomedical Research Support Grants

The Association recommends that the Congress reject the Administration's request that $1.6 billion be rescinded from the Biomedical Research Support (BRS) program and that adequate funding be provided in FY 1982 to assure real program growth.

Biomedical Research Support (BRS) grants enable recipient institutions, many of which are medical schools, to respond quickly and effectively to emerging research concepts, techniques and talent and provide support for new central equipment resources and improved facilities which promote productivity by providing access to sophisticated instrumentation which would not otherwise be available.

BRS funds are awarded on a formula basis to institutions that have received a minimum of $200,000 in Public Health Service research grants during the preceding year. Thus, only those institutions seriously engaged in research are eligible for these awards which are often used to allow them to purchase sorely needed advanced equipment.

National Library of Medicine

The National Library of Medicine (NLM) is yet another example of technological innovation that has greatly enhanced patient care and scientific research. The NLM---one of our three national libraries---is the world's largest research library in a single scientific and professional field and is the central resource for the existing national biomedical information system. It's component programs which include a computer-based online Medical Literature Analysis and Retrival System, a regional library service, the Lister Hill National Center for biological communications, a grants program aimed at improving and expanding health science libraries, and a toxicology information program enabling researchers and practicing physicians to have access to the most current medical 'nformation. Without a doubt, the ability of the NLM to facilitate the transfer of the newest medical technology from the medical school's research laboratory to patient settings is virtually unsurpassed.

Based on NLM's enormous contribution to patient care as well as biomedical research, the Association recommends the Congress appropriate $53,730,000 for FY 1982. Further, we urge that the President's $341 thousand rescission request be denied.

ADAMHA

The Association supports the recommendation of the Coalition for Health Funding that $1,315,447,000 be budgeted for the Alcohol, Drug Abuse and Mental Health Administration in FY 1982.

The AAMC is appalled at the Administration's recommendation which amounts to wholesale dismantling of this agency.

Specifically, according to the current proposal, ADAMHA's research and training funds would be reduced by over 17.2 percent in mental health and 5.4 percent in drug abuse in FY 1982. Moreover, mental health clinical training programs are scheduled to be hased out despite the fact that the Graduate Medical Eduation National Advisory Committee (GMENAC) specifically identified psychiatry as a shortage specialty.

Considering the magnitude of the problems the ADAMHA was created to address, it is difficult to imagine why research and training for individuals newly engaged in such endeavors is being targetted for such debilitating reductions.

CDC

The Center for Disease Control (CDC) performs an invaluable service to the nation under its broad mandate to control and prevent disease and disability.

Many of the CDC's activities, particularly epidemiological studies and the National Institute of Occupational Safety and Health's research, can not be replicated at the state or local level. They are by necessity national in scope and require a concentration of scientific expertise if they are to be carried out efficiently and effectively. Therefore, we recommend that the CDC be funded at $374,574,000 in FY 1982. Further, the proposed rescissions which would endanger the CDC's ability to conduct scientific research essential to health promotion should be explicitedly rejected as contrary to the national interest.

The National Centers for Health Statistics, Health Care Technology and Health Services Research

The Centers for Health Statistics, Health Care Technology and Health Services Research provide our nation with irreplaceable capability for marshaling studies essential to achieving the maximum utilization of scarce health resources. The work performed under the direction of the National Centers greatly enhances our ability to plan for future health services needs and effect the expedient transfer of new health technology.

The Association, therefore, recommends a FY 1982 appropriation level of $84,784,000 and that the Centers current budget be sustained intact. Considering, the pervasive and justifiable concern about the rapid escalation in the cost of health care, it is counterproductive to financially cripple the Centers by enacting a FY 1982 budget which represents a 23 percent loss over FY 1980. Compromising the mission of the three Centers by administrative consolidation or financial deprivation would impair the ability of both the public and private sector to make informed policy decisions.

If these three Centers did not exist, we would be clamoring about the need to create similar entities as we live in an increasingly information-dependent age which renders the services they provide nothing short of indispensable.

Summary

The AAMC appreciates having this opportunity to indicate our particular concerns with regard to the appropriations for the upcoming fiscal year and the rescission for the current one.

It is the AAMC's conviction that while the current economic picture demands fiscal prudence, it is vitally important that the Congress bear in mind that for the truly modest investment for health education and research programs the Association is recommending, the Nation will receive an incalcuable benefit.

MODULE FOR TESTIMONY BEFORE HOUSE AND SENATE APPROPRIATIONS COMMITTEES ON TRAINING

The President's budget request for funds to support National Research Service Awards (NRSA's)is $133.8 million, $55 million less than the amount available in FY 1981; in addition, the level proposed for FY 1981, after rescission, is $132 million, $56 million less than the current level. The bulk of this request is for programs administered by the NIH, lesser amounts are for those of the ADAMHA (NIMH, NIDR and NIAAA) as well as for other components of the Public Health Service.

Expurgation of training for research from the portfolio of Federal programs has become a prime target of the OMB since the late 1960's. Fortunately for the nation, the Congress has consistently frustrated this OMB ambition, recognizing that:

- The large, important and popular investments of the USA in biomedical research should not be placed in the jeopardy that would ensue, were not a constant stream of highly selected, highly trained, highly original and highly creative scientists being developed.
- The election by a student to seek a career in scientific research, unlike one in medicine, is not a guarantee of propriety. Rather it begins a venture frought with risk and uncertainty. If the cream of our scientifically inclined young people are to be attracted to research in the biomedical sciences, incentives must be provided.
- The complexity of modern science places enormous demands---personal and materiel---on institutions that wish to participate in the development of scientists for its workforce. Nothing short of the highest quality training environment will produce scientific investigators of the calibre that today's Federally sponsored biomedical research programs warrant. The development and maintenance of such a training milieu on their own is beyond the capability of institutions of higher education. Federal subsidy is necessary.

Recognizing these realities, the Congress has consistently restored Executive Branch curtailments in the funding of training programs. The Association urges that again this year, the precedents of the past be observed.

This nation has mounted a program of research in the biomedical sciences that is the envy of the world. The yield has been breathtaking. Enormous strides have been made in unlocking nature's secrets. A veritable revolution has been wrought in the biological sciences. Medical sciences have been transformed. A welter of applications have been made to human disease, with spectacular reductions in morbidity and mortality across a broad spectrum of problems. Without scientists of rare and unusual talent, these accomplishments would not have occurred. And without the NRSA's and their antecedent training and followship programs, scientists of this mettle and in those numbers would never have been produced. A research program is no better than the scientists who conduct it. If the nation wants a first rate research program, it must include, as an integral cost, the training of the manpower for it.

What does the President propose? He wishes: to reduce by 5% the total number of trainees; to deny the schools engaged in training the institutional allowances paid them in the past; and to suspend reimbursement of the already limited indirect costs associated with training.

Let us examine each of these proposals.

Numbers. The responsibility for determining the number of trainees required to maintain the integrity of our national system for biomedical research was assigned to the National Academy of Science (NAS) in 1974 in an effort by the Congress to get as objective assessment of national needs as possible. No President has ever requested funds to support the number recommended by the NAS; the Congress has paid more attention to those NAS recommendation and, as a matter of fact, has added funds for training almost every year for the best part of a decade. It should be noted that the NAS projections of need may be conservative and understate the true need for Federal support. The NAS assumes that the role of the Federal Government is to provide "last dollar"support, that is, to fill the gap after other sources of support for the training programs have been exhausted. Unfortunately, it is extremely difficult to determine whether supported from non-Federal sources post-doctoral physicians enter training programs in the pursuit of clinical or research careers; thus uncertainty surrounds the question of what non-Federal sponsors are paying for and getting. Many feel that the NAS assumption, that half of the required post-doctoral physician training positions will be sponsored by non-Federal sponsors, seriously overestimates this source of support.

All available evidence suggest that the nation is training too few scientists for a research endeavor such as exists in the U.S.A. The future of the nation's very substantial investment in research, made over almost four decades, is endangered whenever the number and the excellence of the research work force falls below par. The Association views the proposed reduction of 500 training opportunities for aspirant scientists as a grave error in judgment.

Indirect Cost Reduction. The President's budget proposes to "stretch" the limited funds requested for training by reducing to zero the already arbitrary "capped" (at 8%) rate of reimbursement for the indirect costs of research training projects. The principal elements in indirect costs include those for heating, air-conditioning, lighting, power, and library services. Surely the administration recognizes the legitimacy of these. Surely they don't expect the laboratories of research trainees to be dark, without electricity to power instruments, freezing in winter and sweltering in summer. Surely they recognize the essentiality that a student writing a thesis on research on the frontiers of science have access to the books and journals that record the past on which contemporary research builds. If so, why then this move? The administration has essentially thrown the burden back on the schools, mandating that these institutions increase their cost sharing, i.e., increase their subsidization of the Federal Government.

The AAMC views this move as unjust and self-defeating. The research effort of the USA in 1981 is a *public* enterprise, a long term investment in finding, through research, ways of preventing, of ameliorating and of reversing the impact of the diseases and disabilities that sicken, age, enfeeble, plague and kill our citizens. It is a public enterprise because our people desperately wish to achieve these goals and the only strategy that will attain them is public investment. Investments of the magnitude required are beyond the capability or the feasibility or the will of the private sector. The proposed budget adjustment forces schools that have worked hard as partners with the government in this noble task to dig into endowment and to expand their already substantial cost sharing, at the expense of many other pressing institutional needs. Thus, the Association's charge that this proposal is unjust. Moreover, many institutions either can't, because they don't have the money, or won't because of other priorities, increase cost sharing. Many may well reluctantly drop out of the program, and splendid training environments, built painstakingly over the last three decades, will collapse. For the government to take an action yielding this outcome is plainly self-defeating.

Institutional Allowances. Finally, the President proposes to eliminate allowances to performer institutions under NRSA instruments (grants to institutions and fellowships to individuals) of training, premised on the proposition that government-sponsored students should not pay more than any other student. When the Federal Government, especially through its Legislative Branch, decided to make an all out attack on health problems that had afflicted man from time immemorial, it was quickly apparent that the supply of top drawer scientists was a serious bottle-neck to mounting a major research effort, and that programs to recognize, select and train potential talent were an imperative. In implementing that policy, the NIH identified academic departments with the with the basic competence to conduct training in specific scientific disciplines and persuaded them to compete, through the peer review system, for grants to expand and improve their capabilities. Once the most promising sites had been chosen, the NIH sought to build traning environments of high excellence, in which young men and women could be provided unparalleled opportunities for developing their talents for careers in this public enterprise of research. For thirty years, the institutional components of training awards have built and sustained superb departments all across the land, laboratories out of which have emerged the scientists whose work has revolutionized biology and medicine, brought untold relief and surcease from suffering, extended so many lives and conferred such renown on our nation. The evidence that these institutional investments paid off is overwhelming. Equally clear is the fact that without them, the quality of training will suffer greviously, at a time when the increasing complexity of science places even more demands on excellence in training programs.

The putative rationale for this action---that the schools are charging the government more than they charge non-government sponsored students---can only be described as pusillanimous. The goal of the government is to develop scientists up to the extraordinarily complex challenges of preventing and curing dreaded diseases. Institutions simply can't create the calibre of program that the times and circumstances require, if their only source of support is to be tuition. Federal investments have been both essential and highly cost effective, in that superb programs, turning out superb scientists, have given the country a far "bigger bang for the buck." What matter it, if a few of the students in the program are not on government stipends, with the associated institutional allowances, and only pay conventional tuition. Can't the accountants see that it is equally to the advantage of the government that these students too profit from the excellence of the programs? After all, where else will most of the so-called "free loaders" spend their working careers, other than in the Federally funded national research enterprise? The gun-barrel accountant vision implied in the rationale for the action is pitiful.

The overall sense one takes away from studying the proposals in the President's budget requests for research training is that they were formulated with meagre knowledge and understanding of this nation's scientific enterprise. Particularly absent is any evidence that the framers of the proposal had any appreciation for the interdependence of research and research training programs. Training programs flourish in distinguished research environments and both enhance and profit from them. In addition, trainees learn by doing and thus constitute a highly intelligent workforce, actually engaged in the technical conduct of the research projects under the close supervision of their mentors. If the trainees were not available, subprofessional technical assistants would have to be hired, often at higher salaries. Incidentally, failure to understand this modus operandi explains many of the misconceptions that led to the imposition of payback requirements on individuals who had more than earned the meagre stipends they received.

The AAMC is strongly persuaded that it is in the best interest of the country to sustain, at levels recommended by the (conservative) NAS, the nation's programs for developing coming generations of biomedical scientific investigators. If the exigencies of the times make a reduction in scale absolutely unavoidable, the Executive should do no more than identify a level of funding that represents the maximum that the nation can afford. Detailed planning for the consequent reduction should be left to the expertise in the cognate Federal agency, the NIH and ADAMHA, in consultation from the private sector scientific community. Arbitrary and ill informed actions such as interdiction of indirect cost reimbursement and of institutional allowances have no place in a task that seeks to do the least possible damage to the vigor, excellence and balance of the spectacularly successful biomedical research apparatus that this nation has created.

Statement of Dr. Peyton E. Weary

MR. CHAIRMAN, I AM PEYTON E. WEARY, M.D., CHAIRMAN OF THE DEPARTMENT OF DERMATOLOGY AT THE UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE AND CHAIRMAN OF THE COUNCIL ON GOVERNMENTAL LIAISON OF THE AMERICAN ACADEMY OF DERMATOLOGY. I AM PRESENTING THIS TESTIMONY ON BEHALF OF THE AMERICAN ACADEMY OF DERMATOLOGY WHOSE MEMBERSHIP OF 5200 REPRESENTS THE MAJORITY OF AMERICAN DERMATOLOGISTS, AND ALSO ON BEHALF OF THE SOCIETY FOR INVESTIGATIVE DERMATOLOGY, THE REPRESENTATIVE ORGANIZATION FOR THE DERMATOLOGIC BIOMEDICAL RESEARCH COMMUNITY.

IT HAS BECOME INCREASINGLY APPARENT THAT ONLY INFREQUENTLY DOES THE CONGRESS HEAR ABOUT THE PROGRESS BEING MADE AS A RESULT OF FEDERAL SUPPORT FOR BIOMEDICAL RESEARCH. I WOULD, THEREFORE, LIKE TO DEVOTE A FEW MOMENTS TO A RECAPITULATION OF TWO EXCITING NEW AVENUES OF RESEARCH IN THE FIELD OF DERMATOLOGIC RESEARCH WHICH PRESAGE IMPROVEMENTS IN OUR ABILITY TO TREAT DISEASES OF THE SKIN MORE EFFECTIVELY.

A NEW SERIES OF VITAMIN A DERIVATIVES HAVE BEEN UNDER INVESTIGATION FOR SEVERAL YEARS BY INVESTIGATORS AT THE N.I.H. AND ELSEWHERE. THESE DRUGS HAVE BEEN FOUND TO BE EXTREMELY EFFECTIVE IN TREATING A GROUP OF INHERITED DISORDERS CALLED ICHTHYOSIS, A CONDITION CHARACTERIZED BY MARKED SCALING AND THICKENING OF THE SKIN HERETOFORE VERY RESISTANT TO TREATMENT. FURTHERMORE, THESE SAME DRUGS ARE REMARKABLY USEFUL IN AMELIORATING THE MOST SEVERE TYPES OF ACNE WHICH CAUSE SEVERE SCARRING AND HAVE EVEN BEEN FOUND TO INFLUENCE PSORIASIS. FINAL APPROVAL OF THESE DRUGS BY THE FDA IS ANXIOUSLY AWAITED BY THE DERMATOLOGY COMMUNITY.

I WOULD ALSO CALL YOUR ATTENTION TO EXCITING NEW INFORMATION ABOUT A CELL CALLED THE LANGERHANS CELL FOUND IN THE SKIN OF MAN AND MANY SPECIES OF ANIMALS. WHILE THIS CELL WAS RECOGNIZED MANY YEARS AGO AS BEING PRESENT, IT HAS NOT BEEN UNTIL THE PAST SEVERAL YEARS, AS THE RESULT OF INVESTIGATIONS PERFORMED IN A NUMBER OF LABORATORIES SUPPORTED BY N.I.H. GRANTS, THAT WE KNOW THIS CELL IS INSTRUMENTAL IN PRODUCING ALLERGIC CONTACT DERMATITIS OF WHICH POISON IVY DERMATITIS IS THE MOST WIDESPREAD EXAMPLE. FURTHERMORE, THERE IS SPECULATION THAT THIS CELL MAY ALSO BE IMPORTANT IN SKIN CANCER PREVENTION AND PROTECTION OF THE BODY FROM CERTAIN VIRAL DISEASES SUCH AS HERPES SIMPLEX. NOW THAT WE RECOGNIZE THE PIVOTAL POSITION OF THIS CELL IT MAY BE POSSIBLE TO DESIGN TREATMENTS TO INFLUENCE THE BEHAVIOR OF THE LANGERHANS CELL AND AFFECT THESE IMPORTANT DISORDERS.

THESE ARE BUT TWO EXAMPLES OF THE MANY OPPORTUNITIES WHICH ARE BEING GENERATED THROUGH FEDERAL SUPPORT FOR RESEARCH IN SKIN DISEASES.

WE WISH TO EXPRESS OUR APPRECIATION THAT THE CONGRESS LAST YEAR DIRECTED THE N.I.H. TO REPORT ON EFFORTS BEING UNDERTAKEN TO IMPLEMENT RECOMMENDATIONS MADE IN THE REPORT ON RESEARCH NEEDS AND PRIORITIES IN DERMATOLOGY PREVIOUSLY SUBMITTED TO THE CONGRESS. WE BELIEVE THE EVIDENCE PRESENTED CLEARLY INDICATES THE NEED FOR GREATLY INCREASED RESEARCH SUPPORT FOR DERMATOLOGIC DISORDERS. ALSO, IT IS INCREASINGLY APPARENT THAT OUR GREATEST NEED HAS BEEN, AND WILL CONTINUE TO BE, AN EXPANDED EFFORT TO RECRUIT, TRAIN AND SUPPORT IN THEIR FORMATIVE YEARS MORE SKILLED YOUNG INVESTIGATORS. WE ARE GREATLY ENCOURAGED BY THE FACT THAT THE N.I.H. HAS CREATED AN INTRAMURAL COMMITTEE TO FACILITATE AND COORDINATE RESEARCH SUPPORT IN THE AREA OF SKIN DISEASES. THIS IS AN IMPORTANT MILESTONE BECAUSE IT CLEARLY ACKNOWLEDGES THE FACT THAT RESEARCH IN SKIN DISEASE IS NOT THE SOLE RESPONSIBILITY OF ANY ONE INSTITUTE, BUT RATHER A SHARED RESPONSIBILITY AMONG A NUMBER OF INSTITUTES AND AGENCIES, AMONG WHICH ARE THE NIADDKD, NIAID, NCI, N.I.A., NIEHS, NIOSH AND THE F.D.A. WE ANTICIPATE THAT THE EXISTING NIH

LIAISON STEERING COMMITTEE, WHICH WAS CREATED BY THE AMERICAN ACADEMY OF DERMATOLOGY'S COUNCIL ON GOVERNMENTAL LIAISON, WILL WORK CLOSELY WITH THIS INTRAMURAL COMMITTEE TO DEVELOP A COORDINATED PROGRAM FOR SKIN-RELATED RESEARCH. WE HOPE THAT THE N.I.H. INTRAMURAL COMMITTEE WILL CAREFULLY EXAMINE THE POSSIBILITY OF CREATING ADDITIONAL SKIN-RELATED INTRAMURAL RESEARCH PROGRAMS IN SOME OF THE OTHER INSTITUTES WHICH HAVE A MAJOR INTEREST IN SKIN DISEASE RESEARCH SUCH AS THE NIADDKD, NIAID AND N.I.A. THIS TYPE OF INITIATIVE WOULD GREATLY ENHANCE OUR ABILITY TO RECRUIT AND TRAIN THE COMPETENT YOUNG INVESTIGATORS WHICH ARE PRESENTLY IN SUCH SHORT SUPPLY.

AS EVIDENCE OF THE NEED FOR INCREASED FUNDING OF SKIN-RELATED RESEARCH, WE WOULD POINT TO THE OUTCOME OF THE RECENT INITIATIVE ANNOUNCED LAST YEAR BY NIOSH TO SOLICIT PROPOSALS FOR RESEARCH IN OCCUPATIONAL SKIN DISEASE. NIOSH COMMITTED A SUM OF 2 MILLION DOLLARS TO SUPPORT THIS EFFORT OVER A PERIOD OF THREE YEARS. IN RESPONSE TO THIS ANNOUNCEMENT, NIOSH HAS ALREADY FUNDED FOUR OF SEVEN EARLY GRANT APPLICATIONS FOR A TOTAL OF 440,000 IN F.Y. 1980, 438,000 IN F.Y. 1981 AND 480,000 IN F.Y. 1982. THUS, TWO-THIRDS OF THE 2 MILLION DOLLARS HAS BEEN COMMITTED ALREADY. IN ADDITION, HOWEVER, NIOSH HAS NOW RECEIVED AN ADDITIONAL 26 GRANT APPLICATIONS WHICH HAVE NOT BEEN REVIEWED, SO IT IS APPARENT THAT THE 2 MILLION DOLLARS IS WOEFULLY INADEQUATE. FOR THIS REASON WE BELIEVE THAT THE CONGRESS SHOULD EARMARK A SUBSTANTIAL SUM OF MONEY IN THE AMOUNT OF 5 MILLION DOLLARS NEXT YEAR TO SUPPORT ADDITIONAL RESEARCH IN OCCUPATIONAL SKIN DISEASE. WHILE EFFORTS TO EARMARK RESEARCH SUPPORT FOR DISEASE ENTITIES IS NOT CONSONANT WITH THE CURRENT MOOD OF THE APPROPRIATIONS HEALTH SUBCOMMITTEES, WE BELIEVE IN THIS INSTANCE, BECAUSE OCCUPATIONAL SKIN DISEASE RESEARCH STARTED OUT AT ALMOST A ZERO SUPPORT LEVEL, THAT A SUBSTANTIAL EFFORT SHOULD BE MADE TO PRIME THE PUMP AND BRING OCCUPATIONAL SKIN DISEASE RESEARCH UP TO A LEVEL COMMENSURATE WITH ITS IMPORTANCE IN TERMS OF PREVALENCE (42% OF ALL NON-ACCIDENTAL OCCUPATIONAL ILLNESS) AND ECONOMIC CONSEQUENCES FOR SOCIETY (APPROXIMATELY 25% OF ALL LOST MAN-HOURS FOR NON-ACCIDENTAL OCCUPATIONAL ILLNESS). FOR THE ABOVE REASON WE WOULD MAKE THE FOLLOWING RECOMMENDATION:

RECOMMENDATION #1: THAT THE NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH BE GRANTED AN ADDITIONAL SUM OF 5 MILLION DOLLARS FOR F.Y. 1982 DESIGNATED TO SUPPORT RESEARCH IN OCCUPATIONAL SKIN DISEASE AND THAT THIS MONEY BE OVER AND ABOVE ANTICIPATED REQUIREMENTS FOR OTHER OCCUPATIONAL DISEASE RESEARCH.

WE ARE FURTHERMORE CONCERNED ABOUT THE FACT THAT TRAINING SUPPORT FOR YOUNG INVESTIGATORS IN OCCUPATIONAL SKIN DISEASE IS NON-EXISTENT IN NIOSH AT PRESENT. THIS FACT SHOULD BE A SOURCE OF GREAT CONCERN TO ALL WHO RECOGNIZE THE IMPORTANCE OF DEVELOPING A SUSTAINED EFFORT TO DEVELOP MEANS TO CORRECT PROBLEMS IN OCCUPATIONAL SKIN DISEASE. FOR THIS REASON WE WOULD MAKE AN ADDITIONAL RECOMMENDATION:

RECOMMENDATION #2: THAT THE CONGRESS GRANT TO THE NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH FOR F.Y. 1982 A SUM OF $500,000 TO INITIATE A PROGRAM TO SUPPORT TRAINING OF YOUNG INVESTIGATORS IN THE FIELD OF OCCUPATIONAL SKIN DISEASE RESEARCH.

THE NATIONAL INSTITUTE OF AGING HAS EXPRESSED A GREAT INTEREST IN RESEARCH RELATED TO THE PROBLEMS OF WOUND HEALING IN THE AGED AND THE SERIOUS CONSEQUENCES OF PRESSURE SORES (BED SORES, DECUBITUS ULCERS) ON THE NUTRITIONAL STATUS, NURSING REQUIREMENTS AND RATE OF INFECTIONS IN THE AGED. THE MAGNITUDE OF THIS PROBLEM HAS NEVER BEEN ADEQUATELY DEFINED, BUT IT IS CERTAINLY A COMMON AND SERIOUS PROBLEM AND UNDOUBTEDLY CONTRIBUTES SUBSTANTIALLY TO THE HIGH COSTS OF CARE FOR THE ELDERLY. THE AGING INSTITUTE IS SERIOUSLY UNDERFUNDED AT PRESENT IN COMPARISON TO ITS BROAD MANDATE. WE BELIEVE SERIOUS CONSIDERATION SHOULD BE GIVEN TO ESTABLISHING IN THIS INSTITUTE CONTRACT RESEARCH SUPPORT FOR THESE CRITICAL PROBLEMS NOTED ABOVE AND FOR THAT REASON WE WOULD MAKE THE FOLLOWING RECOMMENDATION:

RECOMMENDATION #3: THAT THE NATIONAL INSTITUTE OF AGING BE GRANTED A SUM OF 1.5 MILLION DOLLARS FOR F.Y. 1982, DESIGNATED TO SUPPORT RESEARCH IN WOUND HEALING AND PRESSURE SORES IN THE ELDERLY ON A CONTRACTUAL BASIS.

THERE IS CLEAR EVIDENCE THAT THE PRIORITY SCORE CUTOFF LEVELS FOR THE NIAMDD CLUSTER WHICH INCLUDES SKIN DISEASE IS STILL SUBSTANTIALLY LOWER THAN THOSE FOR OTHER CLUSTERS WITHIN THE INSTITUTE. THIS MEANS, OF COURSE, THAT MORE-DESERVING SKIN DISEASE RESEARCH IS NOT BEING FUNDED IN COMPARISON WITH OTHER DISEASE CLUSTERS. WE UNDERSTAND THAT THE CONGRESS IS COMMITTED TO THE CONCEPT OF ESTABLISHING LEVELS OF PARITY FOR PRIORITY SCORE CUTOFFS BETWEEN INSTITUTES AND WITHIN THE INSTITUTES, AND IF THIS IS SO, WE BELIEVE SERIOUS EFFORTS SHOULD BE MADE TO CORRECT THIS OBVIOUS INEQUITY. THIS CAN ONLY BE ACCOMPLISHED APPROPRIATELY BY RECOGNITION OF THE FACT THAT THE NIADDKD REMAINS SERIOUSLY UNDERFUNDED IN COMPARISON TO ITS MANDATE. WE BELIEVE

THE TIME IS AT HAND TO COMMIT SUCH FUNDS TO THIS INSTITUTE AS MAY BE NECESSARY TO ESTABLISH A REALISTIC EQUILIBRIUM WITHIN THE INSTITUTE. THIS WILL, OF NECESSITY, REQUIRE A FAR MORE SUBSTANTIAL COMMITMENT OF FUNDS TO THE INSTITUTE FOR F.Y. 1982 THAN HAS HERETOFORE BEEN GRANTED, BUT WE STRONGLY URGE THIS AS A MAJOR INITIATIVE FOR NEXT YEAR'S APPROPRIATIONS PROCESS. WE WOULD, THEREFORE, RECOMMEND:

RECOMMENDATION #4: THAT THE CONGRESS GRANT SUCH ADDITIONAL FUNDS TO THE NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, DIGESTIVE AND KIDNEY DISEASES FOR F.Y. 1982 AS NECESSARY TO EQUALIZE THE EXTRAMURAL RESEARCH PRIORITY SCORE CUTOFF LEVELS FOR ALL CLUSTERS WITHIN THE INSTITUTE AT A LEVEL COMMENSURATE WITH THE CURRENT HIGHEST LEVEL FOR F.Y. 1980.

THE NIAID ALSO CONTINUES TO BE A SERIOUSLY UNDERFUNDED INSTITUTE IN RELATION TO ITS HEAVY MANDATES IN THE AREAS OF ALLERGY, IMMUNOLOGY AND INFECTIOUS DISEASES. ONCE AGAIN IT IS CLEAR THAT A SERIOUS DISPROPORTION EXISTS BETWEEN FUNDS ALLOCATED FOR RESEARCH IN ALLERGY AND IMMUNOLOGY (35%) IN COMPARISON TO FUNDS ALLOCATED FOR INFECTIOUS DISEASES. WE BELIEVE THE FIELD OF ALLERGY AND IMMUNOLOGY HAS ALREADY BEEN ESTABLISHED AS ONE OF THE MOST EXCITING AND PROMISING AREAS FOR THE GENERATION OF NEW CONCEPTS WHICH MAY REVOLUTIONIZE THE APPROACH TO DISEASE IN MANY DISCIPLINES. TO RETARD THIS PROGRESS MAY SERIOUSLY RETARD EFFORTS IN MANY OTHER INSTITUTES. WE BELIEVE EVERY EFFORT SHOULD BE MADE TO EQUALIZE THE RESEARCH SUPPORT LEVELS WITHIN THIS INSTITUTE. FOR THIS REASON WE WOULD RECOMMEND:

RECOMMENDATION #5: THAT THE NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES BE GRANTED SUFFICIENT ADDITIONAL FUNDS FOR F.Y. 1982 TO EQUALIZE THE RESEARCH SUPPORT LEVELS FOR THE SEVERAL DISCIPLINES WITHIN THE INSTITUTE AND THAT THIS SHOULD NOT BE ACCOMPLISHED BY REDUCTIONS IN THE CURRENT SUPPORT LEVELS FOR ANY DISCIPLINE.

THE INCIDENCE OF MALIGNANT MELANOMA, ONE OF THE MOST AGGRESSIVE OF ALL MALIGNANT TUMORS, IS INCREASING AT A PRODIGIOUS RATE NATIONWIDE. THE INCIDENCE OF MELANOMAS IS INCREASING AT A RATE EXCEEDED ONLY BY TUMORS OF THE LUNG. THE AMERICAN CANCER SOCIETY ESTIMATES THAT 9,500 NEW CASES OF MALIGNANT MELANOMA APPEAR EACH YEAR AND THE AGE ADJUSTED INCIDENCE IS 4.2 PER 100,000 POPULATION. IN CALIFORNIA THE MORTALITY RATE FOR THIS DISEASE DOUBLED BETWEEN 1945 AND 1971 AND THE ANNUAL MORTALITY RATE

IN THE UNITED STATES IS APPROXIMATELY 3,000 PER YEAR. THIS MAY BE A REFLECTION OF THE INCREASED EXPOSURE OF INDIVIDUALS TO OCCUPATIONAL AND RECREATIONAL SUNLIGHT, AMONG OTHER POSSIBLE FACTORS. CURRENTLY, RESEARCH IN MALIGNANT MELANOMA IS SUPPORTED AT A LEVEL OF APPROXIMATELY 3.5 MILLION DOLLARS. IN COMPARISON TO THE TOTAL RESEARCH SUPPORT FOR THE N.C.I., THIS IS NOT AN ADEQUATE LEVEL FOR A DISEASE OF INCREASING INCIDENCE WITH SUCH SERIOUS CONSEQUENCES. WE WOULD, THEREFORE, RECOMMEND:

RECOMMENDATION #6: THAT THE CONGRESS INDICATE THE NEED FOR SPECIAL EMPHASIS IN SUPPORTING RESEARCH IN MALIGNANT MELANOMA IN ITS F.Y. 1982 REPORT.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS OUR CONCERNS AND RECOMMENDATIONS.

STATEMENT OF DR. EDWARD MAUMENEE, JOHNS HOPKINS UNIVERSITY MEDICAL SCHOOL

Senator RUDMAN. The next Institute to be covered is the National Eye Institute.

We have today with us Senator Mathias, who would like to introduce to the subcommittee one of the witnesses.

In addition, we have Mr. Durward McDaniel and Mrs. Sylvia N. Rachlin.

Senator SCHMITT. Senator Mathias, would you like to introduce your distinguished constituent?

Senator MATHIAS. Thank you very much, Mr. Chairman.

It is an honor for me to be here today, not to introduce Dr. Maumenee to the committee, because he has testified before the Senate many times, but to present him here this morning.

Johns Hopkins Hospital, we say today, the Johns Hopkins Institutions, not just the hospital, but the whole medical structure of the Johns Hopkins University, has become world famous.

People travel from the ends of the earth to consult at Johns Hopkins, to study at Johns Hopkins, to be treated at Johns Hopkins.

We in Maryland are very proud of that global reputation which Johns Hopkins has brought to Maryland. But I think we have to recognize that it is so only because of the kind of people who have worked at Johns Hopkins.

Dr. Maumenee is an example of that extraordinary kind of human being who combines great distinction in science with a sense of humanity and compassion which makes it possible to provide the kinds of help in a meaningful way to human beings in a wide variety of scientific disciplines.

He is professor emeritus of ophthalmology and former director of the Wilmer Institute of Johns Hopkins.

So he has had an extraordinary career in helping people who have eyes to see.

Perhaps when he comes to talk to us here in the Congress, he engages in an even more difficult task, that of helping those who have eyes and see not.

But I am sure that he will be very persuasive to this committee and it is my pleasure to be here to help the committee greet him this morning.

Senator SCHMITT. Thank you, Senator Mathias, obviously the subcommittee and full Appropriations Committee miss your presence on this committee.

We know you had to make a very difficult choice in going to serve in another area. We appreciate you being here to introduce Dr. Maumenee.

I would say, also, that Senator Hollings had hoped to be here to welcome you, sir, and he has found he is unable to make it.

I suspect because of Budget Committee activity that's going hot and heavy at the present time, but he wishes to extend his best regards to you.

Senator MATHIAS. I miss being here, but I am convinced that you always do the right thing. But as I leave, I will leave you with a threat that if you don't, I will come back and haunt you. [Laughter.]

Senator SCHMITT. Now, Doctor, since we have such an introduction, perhaps you would like to proceed further.

The committee will allot 5 minutes to each of our three witnesses and please proceed, Doctor.

Dr. MAUMENEE. Thank you very much, Senator Schmitt.

I certainly want to thank Senator Mathias for coming to give me such a wonderful introduction and to say that as a Marylander, we are very proud of his leadership in the Senate and his support of the National Institutes of Health, and particularly the National Eye Institute.

I have a prepared statement which I will turn in, but won't try to cover that. But I will more or less ad lib on some points about ophthalmology in the 5 minutes I have.

We are asking for $162,222,000 as the citizens budget for the appropriations for this year.

This includes $10 million for construction and renovation of facilities. I think the things that have been accomplished in ophthalmology in the past show that the money that you have given us since 1968 and slightly before that has been extremely well spent.

We have been able to reduce the stay of patients for a cataract extraction from 8 days to 2 or 3 days in the hospital.

This, alone, is $500 million a year, since somewhere around 400,000 people have cataract extractions each year.

Similarly, in diabetes, with the diabetic board of regulations study that has been done through the National Institute, we have shown that we have been able to prevent blindness in some 60 percent of the people with advanced retinopathy.

Senator SCHMITT. Senator Hollings, thank you for coming down. I just told everybody you were busy and couldn't make it. Would you want to ask any questions?

Senator HOLLINGS. I did want to come in to substantiate the superb work done by the witness. This public witness, Dr. Ed Maumenee, saved my eyesight.

When you fool around with the eyes, I get as meticulous as Harrison Schmitt, I had the best in the world, Dr. Maumenee and his whole group. We have had him up in our hearings for appropriations.

I think there is a slight increase that we are trying to hold on upstairs, I am cutting everybody's budget, but we will do our dead-level best for you and I do appreciate your appearing here in Washington today to make this presentation.

Thank you very, very much.

Senator SCHMITT. I know everybody appreciates your interest in this and the very personal interest that you bring to it.

It is amazing how persuasive a personal involvement can be.

Senator HOLLINGS. We have an alumni group——

Dr. MAUMENEE. I must tell you, we really appreciate that alumni group.

Senator RUDMAN. Please continue, Doctor.

Dr. MAUMENEE. I was just saying with the photocoagulation study, we have been able to save 60 percent of the people with fairly advanced retinopathy and we are now in the stage of an early trial for seeing if we can prevent even more people from going blind.

As far as cataracts are concerned, we do have a very successful method of surgery now.

And several Senators have been operated on and are back on the floor in 2 or 3 days after the operation, functioning quite adequately.

But this is not the solution to cataracts. We really want to find out what the basic cause of cataracts is.

And through studying sugar cataracts, that is cataracts caused by diabetes in experimental animals and in humans, it has been found that the cause of the cataracts is an increase in the sugar alcohols in the lens.

And the National Institute has found that this can be blocked by blocking out aldose reductase, which is an abnormal breakdown of sugar.

In cooperation with industry, after the basic research has been done, the National Institute has now farmed out to 12 pharmaceutical houses the type of aldose reductase prohibitor we have wanted developed.

They have developed one now that will totally block cataract formation. This is the first time in history there has been any medical treatment for cataracts.

It is a most exciting breakthrough. Not only does this have implication as far as cataracts are concerned, but it also has great implications as far as diabetic neuropathy is concerned and the vascular disease in diabetes.

Ms. Rachlin said I could have 4 minutes of her time because she's only going to use 1.

Senator SCHMITT. Please proceed.

I would also remind you of some of the work going on to improve the delivery of insulin to diabetic patients such as the artificial anchors.

That may have a significant improvement in this area, also.

Dr. MAUMENEE. I think it is a long thing to get into, but simply the automatic deliverer of insulin is very good because that allows the body to break down the insulin in its normal pathway.

It's only when you get a buildup of hyperglycemia that the aldose reductase comes in, and so I think that is a very good opportunity within the last few years that it may begin to solve the problems of the vascular disease.

It takes 10 or 15 years for a juvenile diabetic.

Senator Schmitt. It is good to see New Mexico and Maryland working together.

Dr. MAUMENEE. We think the eye is the best test tube in the body for study research.

Senator SCHMITT. Please continue, we are both using up time.

Dr. MAUMENEE. Retinal degeneration is another area we think there has been an early breakthrough through that, mice have hyperrenal degeneration very close to people.

Recently at NIH, we found a specific metabolic defect. Just an example of how much the public is interested in ophthalmology problems, I brought along this copy of the Delta Airlines News and one of the principal articles in this is a myopia relief, a description of operation to cure myopia.

Now, this is a procedure that was done first in Russia without proper animal experimentation and without proper clinical trials.

It is going to cost the public millions, if not billions, of dollars for this operation, if it is no good, and if it is good, we certainly want to know about it.

So this is just another example of the type of work that NIH is doing, because now we are going to run a prospective clinical trial and do laboratory experimental works to see if this procedure really is of value in treating and curing myopia or relieving the persons of wearing their glasses.

I could go on to tell you more about the work that's being done involving coma, the work in a lot of genetic disease, but I realize my time is very limited and many of these statements are covered in the written material.

I certainly appreciate your allowing us to testify before you, Senator.

Senator SCHMITT. I appreciate your coming. Your full testimony will be a part of our record and will be studied very carefully.

Now, Mrs. Rachlin?

STATEMENT OF SYLVIA N. RACHLIN, EXECUTIVE VICE PRESIDENT, MYOPIA INTERNATIONAL RESEARCH FOUNDATION, INC.

Mrs. RACHLIN. Yes, thank you.

Senator SCHMITT. Would you like to supplement the testimony with the remaining 1 minute or 2?

Mrs. RACHLIN. That's all I am going to take, Mr. Chairman.

First, thank you so much and your committee, for allowing me to appear before you today.

You have a copy of my printed statement and I just want to add a few comments.

I think you will agree that all appropriations for eye research are in the public interest and I am leaving it to the experts and to the professionals to decide on the budget.

The results of the research is to reduce the tax burden and restore the handicapped to tax roles. The greater the investment, the greater the return, even in these times.

I appeal to you, Mr. Chairman, and committee, to please approve the budget request for the National Institute.

Thank you.

Senator SCHMITT. Thank you very much.

Now, Mr. Durward McDaniel, national representative of the American Council of the Blind.

STATEMENT OF DURWARD McDANIEL, NATIONAL REPRESENTATIVE, AMERICAN COUNCIL OF THE BLIND

Mr. McDANIEL. I appreciate this opportunity to appear on behalf of the Friends of Eye Research.

I am one of the national advisors of that organization and I welcome the opportunity to bring a different, but compatible perspective to the appropriation needs of the National Institute which has had a rather short history, but which has done very effective work and is in the process of a well-planned research program which is going to affect not only those who now have sight problems, but the population throughout the future.

Those people who—some of whom aren't born yet, are going to benefit from the research which is now being done, the training of researchers, and so on.

And the fact that I am not a researcher, but I am a lawyer, but I work for the American Council for the Blind, which has 638 organizations throughout the country.

I think those give an emphasis to the appreciation which we have and the realization of the need that there is for dealing with these unsolved problems now, through the kinds of research which the National Institute is engaged in, we know that the best solution to blindness and the economic and social losses which so often follow blindness is eyesight.

Some of the people in this country, and I am one of them, will not benefit from research because I and many others are not going to have sight restored.

But many billions of people can be saved from blindness and many other billions who perhaps will not have normal sight will have useful and usable sight and thereby be able to function in our society without any impediment or inhibition to doing all of the things that we all need to try to do in our society.

We do believe strongly that reducing expenditures and this kind of operation would be economically and socially counterproductive and would delay some of the progress which was so late in getting started and is so badly needed, not just for us, the present population, with sight impairment, but for all Americans because no one knows who is going to be affected in the future with an eye problem, which could be seriously limiting or blinding, for that matter.

So we strongly support, not just the Friends for Eye Research, but the American Council for Blind, strongly supports the maintenance of the recommended budget figures and we commend the National Institute for its progressive and remedial work.

I would like to request that the written statement submitted be included as part of the committee's hearing record.

Senator SCHMITT. Without objection, it will be included.

And we thank you very much for that testimony on behalf of eye research.

Mr. McDaniel's statement indicates an $8 billion reduction in cost to major visual impairment. Mr. McDaniel, or Dr. Maumenee, do you know of any cost/benefit analysis that has been conducted that measures the benefit of research that has been accomplished to date, in reducing that cost?

Dr. MAUMENEE. I think the $8 billion estimate of the cost of blindness or visual impairment is one that has been discussed, it has also been discussed as $7 billion.

I can cite cataract surgery for one. Reduction of the stay in the hospital for cataract surgery.

Senator SCHMITT. Has anyone made an actual numerical calculation of how much we have saved as a result of cataract surgery or any other investments we have made.

Dr. MAUMENEE. If you take the number of days between 8 and 2 days, and the cost of hospitalization, you can come up with $500 million right there.

That is one way of estimating it.

Senator SCHMITT. Do you know of any studies, that has specifically made those kind of cost/benefit analyses?

Dr. MAUMENEE. The National Institute of Health Program Planning Committee that was published in 1977 has that information in it.

Senator SCHMITT. All right.

We will try to get that for our records, then.

Thank you, panel, for your assistance this morning.

[The statements follow:]

Statement of Dr. A. Edward Maumenee

I am grateful for the opportunity to testify before this distinguished Committee in support of the Citizens' Budget Proposal for the National Eye Institute for Fiscal Year 1982. I am aware that the Congress has many difficult decisions to make in arriving at a national budget that will achieve drastic reduction in the cost of government without jeopardizing its essential activities. You will find in the medical and biomedical research communities the widest and most enthusiastic endorsement of your efforts and those of the President to cut waste, duplication and unnecessary programs from the Federal budget.

Your committee has been especially supportive of the National Eye Institute since its establishment in 1968. You have recognized that this was a young Institute and you have nourished its gradual, natural growth to maturity. In return, the Institute has established a remarkable record of scientific achievement and fiscal responsibility. The Citizens' Proposals for which I have repeatedly testified through the years have not asked for pie in the sky — nor does the budget for which I now ask your support. The figure of $162,222,000 was arrived at through the most diligent study of realistic needs in eye research at this particular point in its progress. The budget we present is a thoughtful extension of the detailed plan developed by the National Eye Council which has won the applause of this Committee and which has served as a model for research planning by other elements of the National Institutes of Health. Our request is the product of long discussion and final consensus agreement among representatives of the public in consultation with professional organizations most deeply concerned with the problems of blindness and the control of blinding diseases. All are conscious of the imperative for fiscal restraint -- and that is reflected in a figure that is less than last year's request and includes no allowance for inflation over the past several years. We do believe, however, that in presenting a Citizens' Budget Request, we have an obligation and a duty to define for you what we see as essential needs -- indeed, minimal needs -- of eye research in dealing with the human catastrophe of visual disability.

A distinguished physician and doctor of philosophy recently cited what he termed, "the high cost of not doing biomedical research." He pointed out that the polio vaccine, at a cost of $41 million is today saving the nation 70 times that amount per year in hospital costs, medical care and the loss of income of those who otherwise would have been polio's victims. Referring to many similar examples the speaker asked, "Why is medical research too often seen as a barely tolerated charity, rather than a country's soundest investment?" He concluded with the thought, "If you think medical research is expensive, try disease." Today we might paraphrase that with the reminder, "If you think eye research is expensive, try blindness."

Four years ago a government report indicated that total costs to the nation at that time as a result of blindness amounted to $7 billion a year. Since that time we may assume that another $28 billion has been so expended. At any one moment more than 10 million people in the United States -- one out of every 20 -- suffer from significant impairment of vision which cannot be further improved by corrective lenses. One and a half million are so severely impaired that they cannot read ordinary print, even with glasses. The legally blind number 500,000. Hundreds of thousands of otherwise healthy people stand continuously on the threshhold of severe visual disability. What all this adds up to is a staggering bill which the people of this nation can little afford, nor should they be expected to tolerate. Against this constant drain of billions of tax dollars and private expenditures we propose a relatively modest budget of $162,222,000 for continuing productive research that returns far more than that amount each year in saving the sight of those who otherwise would be hopelessly disabled. I believe that this Committee, the Congress and the President will find no more productive way of reducing waste in the economy than by your support of this investment in the work of the National Eye Institute.

The ultimate test of eye research lies in what it has accomplished in saving sight — and what it promises to achieve with your support in the foreseeable future. I would like to discuss briefly just a few of the most devastating eye problems and the scientific programs that are directed toward their solution.

Cataracts have afflicted mankind since the beginning of time, blinding millions of people in every era, in every nation, and in every level of society. Last year in the United States more than 400,000 surgical procedures for cataract were performed with more than 98 per cent success in saving sight. In previous appearances before this Committee I have described the scientific concepts, the advanced techniques, instrumentation and surgical materials developed through research which makes such success possible. Hospitalization for cataract has been reduced by as much as eight days, producing a saving in hospital costs alone that exceeds half a billion dollars each year. Patients return quickly to normal life and productive work. With the development of hard, soft and extended-wear contact lenses and intraocular implants, better vision is provided than was ever before possible. Yet these advances reveal only one facet of the cataract research effort.

Events of great consequence are now taking place toward the development of a chemical therapy that may avert the need for cataract surgery for many people. Interest is focussed upon an enzyme, aldose reductase, which research has found to be a causative factor in the formation and growth of "sugar cataracts", a common consequence of diabetes. That discovery set off intensive efforts to find a potent, non-toxic chemical that will safely block the activity of this enzyme without damage to the complex biochemical environment of the human eye. The obstacles have been enormous. Thousands of chemical formulas have been devised, altered, manipulated and tested in laboratory animals. As a result we are now witnessing the emergence of aldose reductase inhibitors with sufficient potency to halt the progression of sugar cataracts in laboratory models of the disease. Clinical trials are being planned to test the inhibitors in diabetics with incipient cataracts. Some of the agents will be tested in humans to see if they can prevent the swelling of the lens that often blurs the vision of juvenile diabetics. There is also evidence that the new chemicals may be useful in post-surgical wound healing of the cornea, often a major problem for diabetic patients.

The intensive effort that has characterized studies of this enzyme has set off a chain of investigations that may lead far beyond their initial objectives. The possibility now arises that aldose reductase may be a basic mechanism responsible for even more serious complications of diabetes, such as peripheral nerve disease and disorders of the small blood vessels. If such is the case, the development of potent enzyme inhibitors may lead to effective treatments for many critically serious conditions associated with this life-threatening disease. I remind you that there are more than 10 million diabetics in the United States, of whom 300,000 are at risk of visual disability. The number is increasing rapidly.

Retinal disorders are responsible for half the incidence of blindness in the United States. They are the most difficult eye disorders to treat and to study. Science has devised instruments and methods for dealing clinically with some of these disorders: the laser, adapted for use in diabetic retinopathy and retinal detachment; vitrectomy, to restore sight after retinal hemorrhaging; scleral buckling, freezing procedures, electronic and photographic techniques to observe, record and diagnose retinal function and dysfunction. Yet, of some 50 known degenerative and genetically determined diseases of the retina, all but three have remained untreatable. The unusual nature of the retina presents obstacles of extraordinary proportions. Today these difficulties are being overcome by laboratory techniques that are opening up the microscopic universe of the retina -- with exciting implications for the treatment of its diseases and genetic disorders.

Human retinal cells obtained from donor eyes are now being kept alive and grown in laboratory cultures. Observations of these tissues in culture disclose critical factors necessary for their survival, revealing the characteristics of normal tissue and how biochemical alterations of cells may be accomplished. These findings are a prelude to the detection of unique biochemical defects present in cells obtained from donors with retinal degenerative and genetic diseases. Such knowledge offers hope that specific treatments may be devised for senile macular degeneration, retinitis pigmentosa and other conditions that have defied all previous efforts at therapy. Most exciting is the possibility that defective cells, lost or devitalized through disease, may some day be replaced by the injection of healthy, normal cells grown in the laboratory. Scientists are already pursuing this ambitious concept.

An important laboratory discovery with direct implications to the treatment of degenerative retinal disorders is the finding of a specific enzyme defect responsible for gyrate atrophy, a condition with many similarities to retinitis pigmentosa. This is the first time that a specific inborn error of metabolism has been pinpointed in human retinal degeneration, the leading cause of blindness among older Americans. The defect causes those with gyrate atrophy to accumulate excessive ornothine, an amino acid, in their blood. Recently it was found that ornothine is toxic to retinal tissue, which establishes a clear connection between defective metabolism and the destruction of the retina. Efforts to treat this disease by diet are being explored. The knowledge obtained from these studies is of major importance to the eventual control of many diseases which cannot now be treated effectively.

Studies in ocular immunology are producing impressive results in efforts to control inflammatory diseases of the eye. In certain diseases, the immune system mistakes normal tissue for invading organisms and launches an attack upon them. Research in laboratory animals indicates that this may be true of uveitis, a group of persistent diseases of the inner eye. Using drugs that suppress the immune response, it is now planned to conduct clinical trials of their efficacy in patients with severe uveitis for whom other medications are ineffective.

The immune system also has been implicated in the chronic, recurrent inflammation of the cornea resulting from herpes infection. This common viral disease afflicts some 300,000 Americans each year. Spreading in near-epidemic proportions, the herpes simplex virus not only causes cold sores, encephalitis and venereal disease, but is the second, leading cause of corneal blindness in the United States. Antiviral drugs have been developed that relieve the active infection. But they have not yet proven effective in blocking recurrent attacks, because a reservoir of virus is often latently harbored in the nervous tissue at the base of the brain. Their recurrent emergence leads to scarring of the cornea and, too often, to eventual blindness. New drugs are under constant development with the aim of both relieving the active inflammation and destroying the hidden virus. Now being postulated is the possibility that recurrence of the disease is due to immunological factors in the majority of persons affected. Research to suppress the immune response is under way.

Time restrictions permit only the most cursory discussion of what amounts to a worldwide catastrophe. Funds allocated to the Eye Institute by Congress have a profound effect upon the lives of many millions of people in this country and throughout the world. More than 1,070,000 Americans are visually impaired from glaucoma, and another million are living with the undiagnosed disease. New families of drugs are being studied which it is hoped will provide more effective therapy. New surgical techniques are being devised for cases which do not respond to medication. Sixty million people are afflicted with myopia, often of such severity that correction with lenses is inadequate. Attempts are continuing to improve the refractive power of the cornea by reshaping it through various procedures,one of which -- called radial keratotomy -- is especially controversial and will be the subject of a clinical field trial to assess its safety as well as its possible effectiveness. Amblyopia, strabismus and other sensory and motor disorders deeply affect the lives of millions of American children, causing visual impairment which often cannot be traced to specific dysfunction of the eye itself. The challenge of these disorders, now being confronted by basic and clinical investigators, merits the full and substantial financial support as incorporated in the Citizens' request.

The National Eye Council is now completing the development of its third five-year national plan. Achieved with the cooperation of leaders in ophthalmic science, the plan will provide a blueprint for the rational exploitation of all the knowledge and experience acquired up to the present. So quickly has eye research progressed that opportunities for productive action against blinding diseases are almost limitless. In no other branch of biomedical research has financial support been so quickly and effectively translated into the alleviation of disease, disability, and human suffering -- and at such modest investment of public funds. Given the present economic climate, we have arrived at a Citizens' Budget Proposal which reflects both aggressive pursuit of obtainable objectives and the acceptance of fiscal realities. The request we present envisions continued progress along lines of investigation now firmly established. It provides for the training of young investigators whose commitment to eye research is essential to the fight against blindness. And it provides modest support for the renovation and construction of adequate research space to carry out the advanced studies that are now possible in clinical and basic ophthalmic science. Last year, a nationwide inquiry revealed that institutions engaged in research under National Eye Institute grants can intelligently and effectively utilize as much as $77,000,000 in funds to renovate and/or construct essential laboratory facilities. In a conservative step to help fill that well-documented need, we are requesting $10,000,000 for this purpose as part of the Citizens' Budget Proposal for Fiscal Year 1982.

It is my hope and urgent request that this Committee recommend approval of the Citizens' Budget Proposal for the National Eye Institute for Fiscal Year 1982. Our request contemplates expenditures in the following program areas; for Retinal and Choroidal Diseases, $58,568,000; for Corneal Diseases, $20,952,000; for Cataract, $12,649,000; for Glaucoma, $13,217,000; for Sensory-Motor Disorders and Rehabilitation, $29,088,000; for Intramural Laboratory and Clinical Research, $12,550,000; for Research Laboratory Construction and Renovation, $10,000,000; and for Research Management and Program Services, $5,198,000. Financial tables related to the proposed budget of $162,222,000 for Fiscal Year 1982 are attached.

I thank you for the opportunity to present this testimony and I welcome the questions of the Committee.

NATIONAL EYE INSTITUTE FINANCING-CITIZENS' PROPOSAL, FY 1982

BY ACTIVITY:	FY 1981 Appropriation	FY 1982 President's Budget Request	FY 1982 Citizens' Proposal
Grants:			
Research	$ 90,259,000	$104,233,000	$110,489,000
Research Laboratory Construction and Renovation	-0-	-0-	10,000,000
Core Center Grants	3,221,000	2,856,000	4,900,000
Specialized Clinical Research Centers	443,000	285,000	885,000
Developmental Clinical Trial Grants	-0-	-0-	4,000,000
Individual Training	1,320,000	1,235,000	2,200,000
Institutional Training	2,946,000	2,524,000	3,800,000
Total Grants	98,189,000	111,133,000	136,274,000
Direct Operations:			
Intramural Laboratory and Clinical Research	10,645,000	11,519,000	11,650,000
Research and Development Contracts	4,301,000	5,801,000	8,200,000
Biometry, Epidemiology and Field Services	800,000	900,000	900,000
Research Management and Program Services	4,620,000	5,048,000	5,198,000
Total Direct Operations	20,366,000	23,268,000	25,948,000
TOTAL OBLIGATIONS	$118,555,000	$134,401,000	$162,222,000

BY PROGRAM:			
Retinal and Choroidal Diseases	$ 44,395,000	$ 50,929,000	$ 58,568,000
Corneal Diseases	15,853,000	18,219,000	20,952,000
Cataract	9,748,000	10,999,000	12,649,000
Glaucoma	10,154,000	11,493,000	13,217,000
Sensory-Motor Disorders and Rehabilitation	22,340,000	25,294,000	29,088,000
Intramural Laboratory and Clinical Research	11,445,000	12,419,000	12,550,000
Research Laboratory Construction and Renovation	-0-	-0-	10,000,000
Research Management and Program Services	4,620,000	5,048,000	5,198,000
TOTAL OBLIGATIONS	$118,555,000	$134,401,000	$162,222,000

Note: Fiscal Year 1982 begins October 1, 1981.

STATEMENT OF SYLVIA N. RACHLIN

THE MYOPIA INTERNATIONAL RESEARCH FOUNDATION urges increased dedication to all research that would promote early detection, treatment and prevention of eye disorders. Healthy eyes in childhood offer greater promise for a happy and productive life.

Deep is our concern for the public health and, more particularly, eye care. Americans spend over five billion dollars annually for eye care. In addition, eye disorders account for suffering to individuals and their families that is beyond all statistical measurement.

The Myopia International Research Foundation has, therefore, sought and secured the joint support of consumer groups in its crusade on behalf of high standards of public health and eye care. Among these groups are the Catholic Daughters of America, the Federation of Jewish Women's Organizations, groups of Protestant Churchwomen, leaders in the Labor Movement, and the Ad Hoc Black Leaders Committee.

The Myopia International Research Foundation is convinced that research into the causes, treatment and prevention of myopia could revolutionize the entire practice of eye care and promote the prevention of blindness. We, therefore, recommend to this Honorable Committee that it give generous support to the requests of the National Eye Institute to make possible adequate grants for research. The returns will prove most beneficial to our nation health and economy.

The Myopia International Research Foundation, Inc. launched the first comprehensive, interdisciplinary research program in the United States into the causes, treatment and prevention of nearsightedness.

Our immediate goal is to save the eyesight of more than one million American children (besides millions around the world) who are doomed to blindness because of progressive, pathological myopia for which there is no known cure. This, we are doing with the cooperation of doctors in the United States and elsewhere throughout the world.

The Myopia International Research Foundation sponsored the First International Conference on Myopia in 1964.

Since 1965 the Myopia International Research Foundation has appeared before Appropriations Sub-committees of the U.S. Senate and House of Representatives appealing for increased support of eye research through the National Eye Institute. In recent years, the Foundation has been one of the two Public Witnesses invited by these committees to present testimony on needed eye research for the entire nation under the National Eye Institute.

The Myopia International Research Foundation has been invited to exhibit at conventions of the American Academy of Ophthalmology and Otolaryngology. An increasing number of ophthalmologists has become interested in our Program.

By invitation, the Myopia International Research Foundation has had exhibits at the International Congresses of Ophthalmology. These presentations were enthusiastically received by eminent doctors from all continents.

The Voice of America broadcast details of our Program to all nations on two occasions.

Through gifts of printing, Myopia Research Papers are published and distributed without charge to interested doctors throughout the world.

The Myopia International Research Foundation is idealistic in its operation. No money whatsoever is spent on any administrative salaries or professional fund raisers.

Our intensive efforts continue daily to help widen the channels of communication among doctors interested in myopia research.

STATEMENT OF DURWARD K. McDANIEL

My name is Durward McDaniel, national representative, American Council of the Blind. We are a group which has considerable interest in seeing that the problems of major visual impairment are solved through additional research. We work closely with Friends of Eye Research, a national citizens organization that reaches more than 20 million people with information about advances in eye research, treatment, and the need for continued progress to win the war against blindness. It is a privilege to represent Friends of Eye Research in asking for greatly expanded eye research because blindness can touch the lives of every one of us.

Somewhere in the world, a person goes blind an average of every 11 minutes. All of us have known people who lost their sight--either members of our own families, neighbors or perhaps friends. A Gallup Poll shows that blindness is second only to cancer as the most feared health problem in our nation.

Research to Prevent Blindness can tell you far better than I exactly what progress has been made since the National Eye Institute began operations 11 years ago. However, speaking on behalf of some 10 million Americans with major uncorrectible visual impairment, I know that more eye research makes sound economic sense. If it had not been for advances in treatment and research, taxpayers would be paying several times more to take care of the needy blind and disabled.

I recently saw a document showing that one new breakthrough in treatment of diabetic blindness will save at least $240 million over the next five years. It also will save the sight of 22,000 of our fellow citizens.

Great as this is, blindness and partial sight loss annually drain some $8 billion from the U.S. economy. That is what it costs in medical-hospital care...governemnt assistance payments... time lost from work, and other expenses too numerous to mention here. Only eye research can prevent doubling this visually impaired population over the next half century. Only eye research and better treatment of blindness can reduce that $8 billion figure in the years just ahead.

As I understand it, the National Eye Institute goes about its work in a businesslike way that has earned the respect of both parties in Congress. It was the first of the National Institutes of Health to have a solid, 5-year plan for future growth and development. It wasn't put together by a bunch of bureaucrats, but reflected the practical thinking of 200 top scientists throughout the nation. Even as I speak, that plan is being updated and improved. The plan has a spending ceiling of just under $200 million, rather than calling for open-ended spending. Even this figure is but a tiny fraction of the $8 billion annual cost of blindness as reported by the National Eye Institute.

Friends of Eye Research applauds efforts to cut both the U.S. Budget and the bureaucracy. Winning the war against blindness is compatible with this because it will mean less government assistance, in the long run. We thus endorse a budget for the eye institute of $162 million in fiscal 1982. As I understand it, this ensures adequate funding for most of the important eye research going on in our country, including individual project grants. It also will provide enough training money to support new scientists. In addition, it will speed the transfer of new knowledge from the laboratory to the patients who need it. Attached is a list of our priorities presented in order of urgency. All are important and will accellerate progress.

I know that many of you are familiar with research and development as an important component of private industry. It usually is measured as a percentage of total activity in that industry. The $162 million we ask is a tiny fraction of the $8 billion problem--which will grow to many times that amount unless we have the foresight to provide funding now. It does not even keep up with the original recommendations made in that five year plan I spoke of earlier. However, it is what we need to continue existing research and expand in important, new directions.

Using the above arguments, Friends of Eye Research also opposes further rescissions or deferral in the fiscal 1981 budget of the eye institute. Already, scientists are feeling the pinch of threatened curtailment because the eye institute quite naturally must wait to see what happens in Congress. Again, we appeal for Congressional understanding in maintaining the original budget of $120.254 million in this fiscal year.

RECOMMENDED BUDGET BY ACTIVITY, FISCAL 1982
(in millions of dollars)

RETINAL & CHOROIDAL	58,568
CORNEAL	20,952
CATARACT	12,649
GLAUCOMA	13,217
SENSORY MOTOR	29,088
SUBTOTAL EXTRAMURAL.......	$134,474
INTRAMURAL	12,550
INDIRECT OPERATIONS	3,631
PROGRAM	1,567
CONSTRUCTION	10,000
TOTAL.......	$162,222

RECOMMENDED BUDGET BY MECHANISM, FISCAL 1982
(in millions of dollars)

I.	Research Projects	$110,596
	(Number of competing grants	346
II.	Research centers (1)	5,785
III.	Other Research (2)	3,893
IV.	Research Training (3)	6,000
V.	R & D Contracts (4)	8,200
VI.	Intramural	12,550
VII.	Direct Operations (5)	3,631
VIII.	Program Management	1,567
IX.	Construction	10,000
	TOTAL.....................	$162,222

(1) All core center grant commitments will be met and eleven new or renewal core center grants will be activated. In addition, all specialized clinical research center grant commitments will be covered and 3 new specialized clinical research center awards will be made.

(2) All commitments for "other" research grants such as research career, academic investigator awards and cooperative clinical research grants will be honored. 21 new research career development opportunities will be awarded.

(3) Training funds of $6 million will pay all minimum costs for research training. This will cover the new stipend schedule established by NIH. These funds will make it possible to honor all commitments and will provide for 127 new trainees.

(4) Contract-The NEI also proposed new clinical trials to determine the effectiveness of Argon Laser Trabecultomy in the treatment of glaucoma, to determine the optimum age for strabismus surgery and study ocular melanoma. Existing contract commitments will be met.

(5) Direct Operations includes funds for eight new positions needed to manage the expanding grant portfolio and provides for the increased cost of doing business and for knowledge transfer activities.

STATEMENT OF DR. SUZANNE OPARIL, ASSOCIATE PROFESSOR OF MEDICINE, UNIVERSITY OF ALABAMA SCHOOL OF MEDICINE

Senator SCHMITT. Our next panel will discuss the research resources. We have three panelists, Dr. Suzanne Oparil, the American Federation of Clinical Research, now associate professor of medicine, University of Alabama School of Medicine; Dr. Ronald Duncan Hunt, professor of comparative pathology, director of New England Regional Primate Research Center; and Dr. Alonzo C. Atencio, assistant dean.

First, Dr. Oparil. You each have 10 minutes.

Dr. OPARIL. I am associate professor of medicine at the University of Alabama School of Medicine and president-elect of the American Federation for Clinical Research.

The AFCR is the largest clinical research organization in the United States and is comprised of 10,000 physician scientists interested in promoting original clinical research by young investigators.

I would like to emphasize at the outset that AFCR's primary focus is on physicians who are embarking on and becoming established in a clinical research career. The future of the entire biomedical research enterprise depends upon the continuing infusion of young, bright, and creative physicians into the research manpower pool. It is this cadre of people we are most interested in supporting and encouraging.

Because of the AFCR's broad concerns about the Nation's clinical research endeavors, I will limit my remarks today to the two areas of the President's proposed budget for NIH that most critically concern our members—research training and investigator-initiated grants.

In recent years, a sharp dropoff in the number of physicians entering careers in clinical research has become apparent. As the attached graph shows, the number of medical doctors in research training supported by NIH has fallen from about 4,100 in 1968 to about 1,800 in 1980—a decline of over 50 percent. Because the physician investigator possesses the unique capabilities and perspectives that spark new ideas and directions for research related to disease processes and that allow the transfer of research laboratory results to patient care, the continuation of this decline bodes ill for American medicine and for the American people.

There are many possible reasons for the decline in physicians interested in pursuing research careers—some of which are under Federal control and others which are not.

One of the disincentives that is clearly within the Government's purview is the vagaries of Federal funding. The AFCR has had the position for several years that unless Federal support for research grants and training is stabilized, young physicians will continue to get the message that pursuit of a research career is a risky and foolish alternative to clinical practice.

There has been some progress in the last few years toward the goal of stabilization in these two areas, but the new administration's budget proposal would not only terminate trends toward stabilization of funding for investigator-initiated grants, but would also essentially dismantle the research training program.

I would like to examine each of the Reagan proposals in these two areas:

Research grants: To save $21 million this year, the President has proposed a rescission of this amount from the current year's budget for research grants. Further, it is our understanding that for fiscal year 1982, the President has asked for a budget of $550 million for competing research grants.

There has been a widely publicized effort in the last few years to provide funding for at least 5,000 competing research proposals each year.

Part of the rationale for building this type of stability in the research grant budget was to send a signal to young and aspiring clinical investigators that their future could be predicted to some extent and that their chances of securing funding for a research project depended upon the quality of their ideas rather than upon the funding situation during the particular year their research ideas were conceived.

The new administration's plan to cut the competing grant budget reverses this signal. We urge that this committee not approve the $21 million rescission request and establish the competing grant budget for fiscal year 1982 at $585 million.

Research training: It is our understanding that the administration's budget plan for research training calls for a $62 million rescission this year and a reduction to $132 million in fiscal year 1982—$54 million below the 1980 level. Apparently, the administration intends to accomplish these reductions in part by reducing the number of trainees from 10,700 in 1980 to approximately 10,000 this year and next year.

It is the opinion of the AFCR that investigator-initiated grants and research training are the foundation of our entire biomedical research effort. For the same reasons that stability is important for research grants, it is important for research training.

Senator SCHMITT. We are going to run out of time on your full statement, it will be included in the record; if you wish to summarize and conclude, it would help our other witnesses.

Dr. OPARIL. In addition to our concern over plans to reduce the total number of research trainees, which we think would be shortsighted and unwise, we also are deeply concerned about the method of stretching the research training budget by eliminating institutional training support and disallowing indirect costs.

We simply think it is necessary to have these moneys in order to properly train future researchers. And that this would be an unwise and really impractical method of reducing funding for biomedical research training.

As strength of our statement, we have stated a number of accomplishments which the American biomedical research establishment has decreased including the decline in cardiovascular disease mortality, the decline in complications of hypertensive diseases, and so on.

Finally, although we, in the clinical research, are very aware of the contingencies that face the Federal Government with respect to the budget, we feel very strongly that the amount of money that would be required to support biomedical research, particularly the area of individual grants and research training in general, is such a small fraction of the total Federal budget for health.

In fact, 1 percent of the health budget is spent on research, and it would be unwise and unfair to the future of the American people to cut this budget in a major way.

Senator Schmitt. Thank you very much. Next witness would be Dr. Ronald Duncan Hunt of the Harvard Medical School.

STATEMENT OF DR. RONALD D. HUNT, PROFESSOR OF COMPARATIVE PATHOLOGY; AND DIRECTOR, NEW ENGLAND REGIONAL PRIMATE RESEARCH CENTER, HARVARD MEDICAL SCHOOL

Dr. Hunt. Thank you. I am here to represent the seven regional research centers which are a component of the Division of Research Resources. These seven centers represent a very unique and valuable biomedical resource within our Nation.

Congress created these in the early 1960's and envisioned a century of progress. Today, without an increase in funding, I have been informed by the director of the program at the NIH that one or more of the centers may have to be closed.

A reduction in this effort would have very serious consequences to biomedical research for the entire NIH. Any apparent savings within the Division of Research Resources would ultimately shift to a greater expense to the various categorical Institutes.

Centers represent one of the most cost-effective programs served by NIH. Each center serves as a resource for the entire biomedical resource, providing the animal resources and professional expertise in support of the many programs supported by the various categorical Institutes.

Last year there were 416 programs in the program, and last year at the New England center we had 47 separate institutions. These programs could not take advantage of the resources of the various research centers, the costs would shift to the various categorical Institutes.

The nonhuman primates predominantly composed of a variety of species of monkeys are very unique animals. They are the closest relatives of human, and only animal studies are best conducted with nonhuman primates, such studies of hepatitis, development of the vaccine came directly from studies in the early days of the primate research centers, mental retardation, malaria, communicative disorders, the list is rather lengthy.

Without primate centers, I feel that these studies will not be performed, not now or in the future. I stress that they won't be conducted in the future because primates simply wouldn't be available. Many of those are endangered or threatened species. Unless we learn how to breed and maintain them in captivity, they will be lost forever.

One of the best examples is a cotton-top monkey, which is the only animal known to mankind which gets a disease close to cancer, specifically carcinoma and lymphoma. That is, we have tried to understand their entire biology, maintaining them, reproducing them, nutritional requirements. This is a formidable undertaking. We are not talking about a single species.

Within the order of primates, there are over 200 separate species, not like breeds of dogs, but separate and distinct species. The budget of primate centers has steadily declined with respect to actual dollars.

A study conducted within NIH submitted to Dr. Fredrickson indicated that compared to 1969 dollars, there has been a 27-percent decline in the budget. In contrast to my submitted statement, the fiscal year 1981 budget is not $17.1 million, but rather $16.2 million which is a no-growth budget.

I am requesting a total of $22.4 million for the entire center program. That is not for expansion, but to maintain the program in its original concept as well as to provide funds to take care of very necessary renovations in facilities which were constructed 20 years ago.

This budget, in contrast to many research budgets, includes both direct and indirect costs. My center alone, the energy costs exceeded $250,000 last year. I think in view of the total health care budget, the increases are rather a small request, a very necessary one if we are going to save this program which could very possibly die.

If it does die, I would fear that it may not be resurrected. If it could be resurrected, it would be done with considerable greater expense than what we are requesting. Thank you.

Senator SCHMITT. Thank you, Doctor.

Now Dr. Atencio from one of my favorite institutions, the University of New Mexico School of Medicine, a school that is rapidly advancing in many different areas, and we are happy to have you here.

Dr. ATENCIO. Thank you.

Senator SCHMITT. When you go back, give my best to Dean Apolatola and all of the others.

I enjoyed the demonstration of the artificial pancreas the other day, another example where we are making some major breakthroughs.

STATEMENT OF DR. ALONZO C. ATENCIO, ASSISTANT DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF COLORADO

Dr. ATENCIO. I am Alonzo Atencio, assistant dean of the school of medicine in professional biochemistry. My area of expertise is in the area of blood coagulation. I study at the University of Colorado, I have been in Stockholm, Sweden, I have made some contribution by applying mathematical models with progesterone and antithrombine 3.

I am here not to speak on behalf of my expertise and research, I am here more or less to address an unrepresented minority group who has been untapped until very recently in the area of science research.

For example, they grew up in the northern part of New Mexico, a small town of Los Penos. My education is a circuitous route. I obtained my Ph. D. when I was 38 years old. I was a minority, had the support out of the minority research program been available, then it would have been shortened.

This is an $18 million program, emanating out of the Division of Research Resources. It represents a need of unrepresented minorities representing the science field.

In 1972–73, we tried to identify for the sake of recruiting faculty members and getting more people involved in the biomedical areas of native Americans and Spanish-speaking natives of our country.

We found that there were only about 18 native American Ph. D.'s in the country and 85 what we called Chicanos. That out of 300,000 researchers is a very meager number. The National Institutes of Health instituted the minority biomedical research program and another program subsequently came into being, called the minority access to research careers.

Results from this program has been significantly one of the most productive from NIH. On page 3, I list some of the people that have participated. About 1,500 have personally been involved and supported by the NIH.

About 1,600 have elected to pursue graduate studies leading to a Ph. D., about 50 have received Ph. D.'s, and as you are aware, training of a scientist is a long tortuous route. You have to go 4 years of college, 4 or 5 years in graduate school, some post-doctoral training, and if you are lucky, you get into a 10-year track—so we are talking about a long-term range training.

About 15 have received Ph. D.s' from the total programs. The interesting part here is that about 76 percent of those graduating with bachelor's degrees from this particular program are going into advanced training.

Those going into medicine will probably create some contributions for the clinical research. They already have 2 or 3 years of research in the laboratories.

The NBS works in part by supporting undergraduates and graduates while they are going in their training, through their college years. Those who elected going into medicine obviously bring the research training with them and go probably into the area of great need now in research.

In terms of cost effectiveness and productivity, the productivity in publication has increased tremendously by this group represented by 80 so-called minority institutions. In terms of cost effectiveness, I believe it is estimated about $4,500 for undergraduate and about $8,800 per graduate student compared to some other $11,000 NIH.

In terms of research grants, the average research grant is about $25,900 on the average compared to $88,000 for the regular RO1 support. That means these supported research programs are about one-third of NIH-supported programs and less than other graduate student support.

If you view these figures in another way and consider 37 percent of the support goes for students, it comes to about $3,500 per student. That is a very low figure and very cost effective.

In terms of cost benefit, I already mentioned 76 percent of the students are going into graduate work or graduate training. On the last page I list a table where the minority environment of the supporting program out of the division of research is the only program which received a 7-percent cut. Other programs, although not adequately funded, are still slightly above the 1980 actual appropriations.

I will recommend that the NBS and the MARC program which emanates out of the national—it's only a matter of about $4 million that they are being cut, 200 from the NBS and 200 from the MARC program, that both of those complement each other.

The MARC program had moved that up in that presentation, is just being reduced by 56 percent. They create not only grad students, but also faculty members. I guess we continue at the same present rate of growth; $16 million recommended cut, and back to $18 million would probably be initialed for the last year, the similar initiation for the MARC program.

Senator SCHMITT. Thank you very much. You have pointed out, once again, how little attention we seem to be paying to the great shortfall in researchers, advanced degree personnel in this country, estimated in recent hearings I held in Albuquerque to the approaching 15,000 a year across the board.

In these fields we are going to have to tap all of the researchers of the country, including those which you are representing here today.

We appreciate the testimony. We appreciate the testimony from the panel very much.

[The statements follow:]

STATEMENT OF DR. SUZANNE OPARIL

I am Suzanne Oparil, Associate Professor of Medicine at the University of Alabama School of Medicine and President-Elect of the American Federation for Clinical Research. The AFCR is the largest clinical research organization in the United States and is comprised of 10,000 physician scientists interested in promoting original clinical research by young investigators. I would like to emphasize at the outset that AFCR's primary focus is on physicians who are embarking on and becoming established in a clinical research career. The future of the entire biomedical research enterprise depends upon the continuing infusion of young, bright, and creative physicians into the research manpower pool. It is this cadre of people we are most interested in supporting and encouraging.

Because of the AFCR's broad concerns about the nation's clinical research endeavors, I will limit my remarks today to the two areas of the President's proposed budget for NIH that most critically concern our members--research training and investigator-initiated grants.

In recent years, a sharp drop-off in the number of physicians entering careers in clinical research has become apparent. As the attached graph shows, the number of MDs in research training supported by NIH has fallen from about 4,100 in 1968 to about 1800 in 1980--a decline of over 50%. Because the physician investigator possesses the unique capabilities and perspectives that spark new ideas and directions for research related to disease processes and that allow the transfer of research laboratory results to patient care, the continuation of this decline bodes ill for American medicine and for the American people.

There are many possible reasons for the decline in physicians interested in pursuing research careers--some of which are under Federal control and others which are not. One of the disincentives that is clearly within the government's purview is the vagaries of Federal funding. The AFCR has had the position for several years that unless Federal support for research grants and training is stabilized, young physicians will continue to get the message that pursuit of a research career is a risky and foolish alternative to clinical practice. There has been some progress in the last few years toward the goal of stabilization in these two areas, but the new Administration's budget proposal would not only terminate the trend towards stabilization of funding for investigator-initiated grants but would also essentially dismantle the research training program.

I would like to examine each of the Reagan proposals in these two areas:

Research Grants

To save $21 million this year, the President has proposed a rescission of this amount from the current year's budget for research grants. Further, it is our understanding that for FY 1982, the President has asked for a budget of $550 million for competing research grants. There has been a widely publicized effort in the last few years to provide funding for at least 5,000 competing research proposals each year. Part of the rationale for building this type of stability in the research grant budget was to send a "signal" to young and aspiring clinical investigators that their future could be predicted to some extent and that their chances of securing funding for a research project depended upon the quality of their ideas rather than upon the funding situation during the particular year their research ideas were conceived. The new Administration's plan to cut the competing grant budget reverses this "signal." We urge that this Committee not approve the $21 million rescission request and establish the competing grant budget for FY 1982 at $585 million.

Research Training

It is our understanding that the Administration's budget plan for research training calls for a $62 million rescission this year and a reduction to $132 million in FY 1982--$56 million below the 1980 level. Apparently, the Administration intends to accomplish these reductions in part by reducing the number of trainees from 10,700 in 1980 to approximately 10,000 this year and next year. It is the opinion of the AFCR that investigator-initiated grants and research training are the foundation of our entire biomedical research effort. For the same reasons that stability is important for research grants, it is important for research training.

In addition to our concern over plans to reduce the total number of research trainees-a move we believe to be short-sighted and very unwise--we are also deeply concerned about the proposed method of "stretching" the research training budget by eliminating institutional training support and disallowing indirect costs. In our opinion, this proposal would take the foundation out from under research training. For decades, the institutions that provide research training have had an effective partnership with the Federal government. The Federal government has recognized that the training of research manpower is in the national interest and has provided support for those institutions to build and maintain a strong training environment. In return, the research training institutions have invested time, money and energy and have produced world-renowned scientists. A brief, and by no means complete, list of some of the accomplishments in the last decade of the scientists trained by this joint effort includes:

- A 10% decline in morbidity and mortality in cardiovascular diseases
- A 20% decline in complications of hypertensive disease
- The birth weight survival rate has dropped from 3 pounds to 1½ pounds
- Morbidity and mortality for congenital heart disease had dropped from 90 to 75%
- In 1975, 5% or less of cancer was curable; today approximately half is curable
- The understanding, detection, and management of virtually every disease has improved.

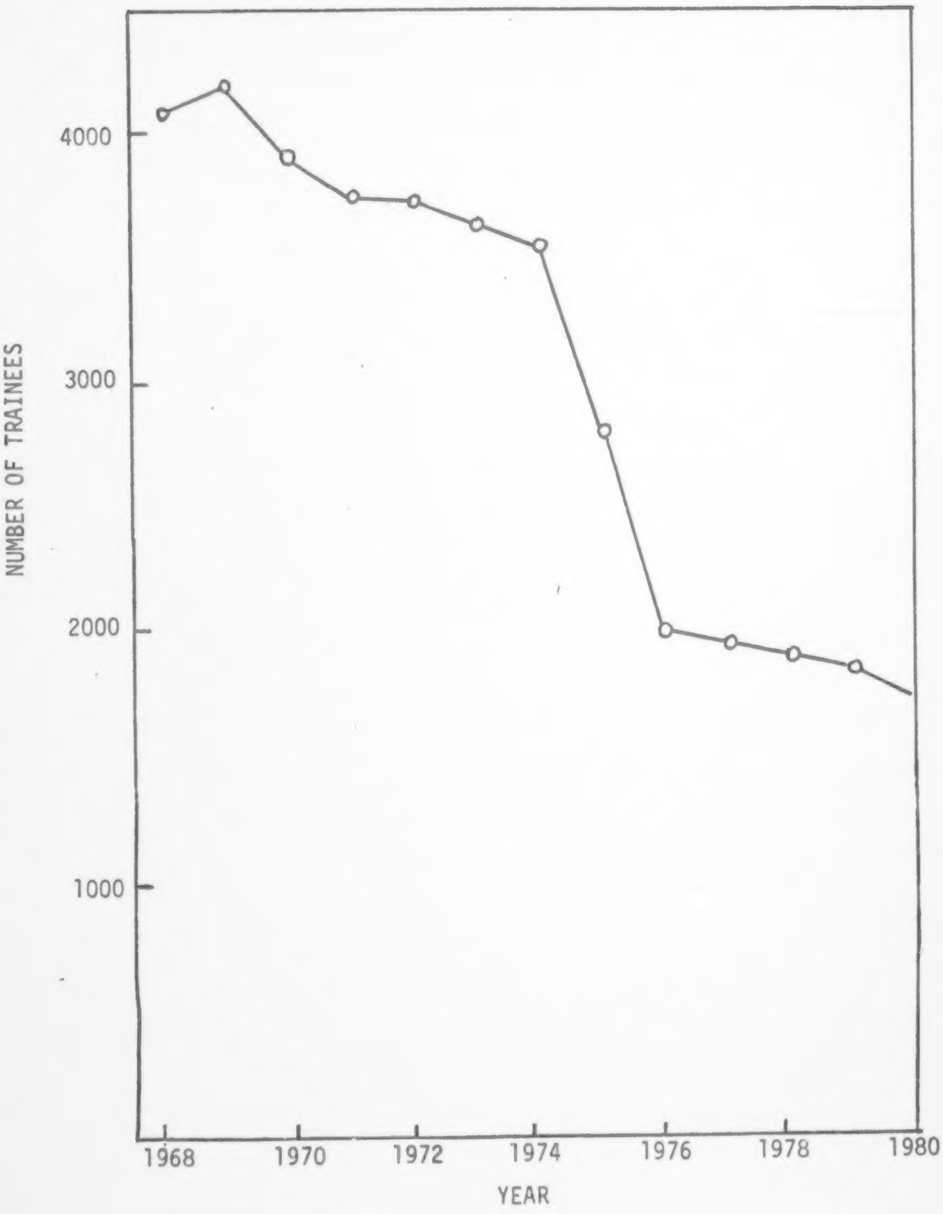
At a time when academic medical institutions are under increasing financial pressure, the outcome of the Administration's proposals to eliminate institutional allowances and reduce support of indirect costs is predictable. These institutions will not continue to provide research training; many of the established, excellent programs will fold; and a bright and promising generation of clinical investigators will be lost.

The AFCR is cognizant of the difficult task facing this Committee. There is a strong national desire to reverse economic trends by cutting the Federal budget. In fact, the AFCR would agree with much of the philosophy of the new Administration to reduce Federal regulation and to emphasize science and industry productivity. But we are puzzled by the apparent conflict between espoused principles on the one hand and the budget cuts on the other. For instance, it is recognized that NIH as a whole fared better than many other agencies in the budget paring process and that this is consistent with the Administration's commitment to support biomedical research. But when we look at how the NIH reductions are distributed, our conclusion was that the proposed cuts are not equitable and do not reflect the stated "commitment to Federal support of essential biomedical research activities." The cuts in research training and research grants will undoubtedly result in a reduction in qualified and productive researchers to carry out the investigation the Administration says it wants. For example, if the budget for research training is not restored, there will not be adequately prepared clinical researchers to run the cancer centers, to direct the diabetes centers, to participate in the intramural program, and to continue the search for knowledge that has extended lives, relieved suffering, and been the pride of this nation.

Our message is that while biomedical research programs are intertwined and interdependent, the foundation and future of the entire enterprise rests on funding for individual investigators and for training future researchers. If cuts must be made, they must be made equitably and should not threaten the foundation that has been built carefully and exceedingly well over many years. For these reasons, we ask the Committee to (1) not approve the rescissions proposed for research grants and research training and (2) establish funding levels for FY 1982 at $585 million for grants and $190 million for training in order to provide stability in these areas. If our recommendations are accepted an additional $83 million this year and $90 million next year would be added to the Reagan budget plan. If you compare these figures to a total Federal health budget of $250 billion, I think you will agree that this almost insignificant investment in the future of biomedical research is an appropriate Federal expenditure. The total NIH budget is just over 1% of the Federal health budget. No other industry or enterprise in this country could survive by investing only 1% of its budget in research and development.

Thank you for considering our views. I would be happy to answer any questions.

POSTDOCTURAL RESEARCH TRAINEES
SUPPORTED BY NIH, 1968-80



STATEMENT OF DR. RONALD DUNCAN HUNT

I am Ronald D. Hunt, Director of the New England Regional Primate Research Center and Professor of Comparative Pathology at the Harvard Medical School. It is a privilege to appear before you as the representative of the seven regional Primate Research Centers. I am requesting an additional $5,250,000 for this program, or $750,000 for each Center. I am not asking for expansion, but seeking funds to maintain the program at present level.

The seven regional Primate Research Centers comprise one of the most unique and valuable resources within the Nation. The wisdom that Congress displayed in creating this long-term program in the 1960's showed forethought. Without a substantial increase in funding, however, I have been informed by the Director of this Program at the National Institutes of Health that one or more of the seven Centers may have to be closed. Reduction in the effort at a time when we should be considering expansion of the program would have very serious consequences to biomedical research supported by the National Institutes of Health. Apparent savings here would ultimately shift a greater expense to other Institutes.

Primate Centers are one of the most cost effective programs supported by the National Institutes of Health. Each Center serves as a resource for the entire biomedical community, providing facilities for the care, management and utilization of non-human primates, professional and technical experts to assist the collaborative scientists, and ensuring supply of non-human primates. Last year 416 research programs of scientists from a multitude of institutions depended upon the resources of the Centers. At the New England Center alone, our resources support programs at the Harvard Medical School, School of Public Health and School of Dental Medicine, Boston University, Tufts University, Brown University, Yale University, University of Lowell, of Massachusetts, of Chicago, The Worcester Foundation, Children's Hospital of Boston, the Massachusetts Institute of Technology, to mention a few (see attached list). These programs which have been reviewed and supported by the

N.I.H. either could not be performed or would require the creation of very costly resources at each of the many participating institutions.

Non-human primates are man's closest relative in the animal kingdom and are therefore indispensable in the effort to understand and control problems of human health. Many critical studies of human health can only be conducted in non-human primates, and others are best conducted in them. Without the Primate Centers Program, however, these studies will not be performed, now or in the future, at a loss to society that no one can hazard to estimate. These studies won't be performed in the future because primates simply won't be available. Many are endangered species. Unless we learn how to maintain and breed them, those species will be lost forever. As an example, the cotton-top marmoset, a small monkey from South America, is the only animal known to mankind that is susceptible to the one and only virus thought to cause cancer in human beings. It is entirely possible, in fact likely, that without the Primate Centers Program this animal will go extinct and be unavailable for the research we simply cannot do on human beings.

The budget of the Primate Research Centers has steadily declined. In a study conducted by N.I.H. and submitted to its Director, the 1980 budget reflects a 27% decline as compared to 1969 dollars (see attached chart). About 250 billion dollars will be spent on Health Care in the United States this coming year, $3.5 billion of that for the National Institutes of health alone. The requested budget of $22.4 million for the Centers represents a small fraction of N.I.H. expenditures yet is a necessary support to a much greater share of the remaining N.I.H. investment.

It is important for the Committee to recognize that the total Primate Centers appropriation includes indirect costs. Indirect costs are not a separate negotiable item in our budgets as they are within the usual government grants system. At my Center alone, energy costs exceeded $250,000 in 1980. If we are to realize the "Century" of effort that Congress foresaw when they created the Centers, the proposed budget must be significantly increased.

Because the Primate Centers Program budget is included in the Animal Resources Branch budget of the Division of Research Resources, the increase must be specifically designated for Primate Research Centers.

In view of our total health budget, this increase is a very small investment for the greater cost effectiveness of any level of research funding allocated through the PHS -- and particularly small when compared with the rewards of improved health for our Nation.

Thank you, Mr. Chairman, for the opportunity to testify.

TABLE I

EFFECT OF INFLATION ON PRIMATE CENTER FUNDING

(1969 - 1980)

Year	Biomedical R&D Price Index	ARP - Primate Centers Funding		
		Total Dollars Awarded	Dollars Adjusted To 1969 Base	% Change From 1969 Base
1969	100.00	$10,500,000	$10,500,000	- -
1970	106.28	9,907,000	9,321,603	-11.22
1971	112.45	10,500,000	9,337,483	-11.07
1972	118.04	11,107,000	9,409,522	-10.39
1973	123.67	10,847,000	8,770,923	-16.46
1974	131.54	11,574,000	8,798,844	-16.20
1975	145.60	11,146,000	7,655,219	-27.09
1976	156.48	13,706,034	8,758,967	-16.58
1977	168.94	13,880,581	8,216,279	-21.75
1978	181.52	14,479,336	7,976,717	-24.03
1979	196.48	15,221,069	7,746,880	-26.22
1980	213.95	16,333,965	7,634,478	-27.29

COLLABORATIVE RESEARCH WITH OTHER INSTITUTIONS

Institution	Principal Investigators	Their Associates	Collaborators with PRC Core Staff
Boston University School of Medicine	2	1	
Brown University School of Medicine	1	3	
Brown University/Rhode Island Hospital	1	3	
Harvard University School of Dental Medicine	2	4	1
Harvard University School of Medicine	3	9	4
Harvard School of Public Health			1
Harvard Museum of Comparative Zoology			1
Affiliated Hospitals			
Boston Hospital for Women	1	2	1
Children's Hospital Medical Center	1	3	2
Forsyth Dental Center	1	1	
Massachusetts General Hospital	1	2	1
Peter Bent Brigham Hospital	1	1	
Sydney Farber Cancer Institute	1	2	
Massachusetts Institute of Technology	1	2	
University of Massachusetts Medical School	2		4
University of Chicago	1	2	
Tufts University School of Medicine	1		1
Yale University	1	5	
Case Western Reserve University	1	1	
Worcester Foundation for Exper. Biology	2	1	
N.I.H., Bethesda, MD			1
Center for Blood Research, Boston			1
Mount Sinai Medical Center, New York		1	2
Rega Institute, Leuven			1
Dr. Karl Cantell, Helsinki, Finland			1
University of Washington, Seattle			1
V.A. Medical Center, Memphis			1
Dr. Jan Fischer, Zurich, Switzerland			1
University of Erlangen, Germany			1
Institut fur Hygiene, Freiburg, Germany			1
National Institute of Drug Abuse, Louisville			1
The Methodist Hospital, Houston, TX			1
Children's Hospital, Philadelphia			1
Institute for Tumorbiologi, Sweden			1
Tulane University			1
University of Connecticut			2
Institute for Virology, West Germany			3
Hospital Sainte-Justine, Montreal			1
University of New Mexico			1
Frederick Cancer Center, Frederick, MD			1
Smithsonian:National Zoological Park			1
Walter Reed Hospital			1
Cancer Institute of France			1
Meloy Laboratories			1
Inst. for Basic Research on Mental Retard.			1
Max von Pettenkoffer Institute, Munich			1
Rush-Presbyterian-St. Luke's Hospital			1
	24	43	47

Total Collaborative Use 114

STATEMENT OF ALONZO C. ATENCIO, PH. D.

INTRODUCTION

Although ethnic minority groups comprise more than 18 percent of this country's total population, they make up less than 5 percent of the science and engineering workforce. The mission of the Minority Biomedical Support (MBS) Program is to increase the number and quality of minority biomedical research scientists. The program was established in response to this dearth of minority scientists available to participate in the National Institutes of Health (NIH) research effort. In 1974 minorities (Blacks, Asians, and other) comprised only 5.14% of the total science work force (excluding engineering).

Several factors appear to have contributed to the low percentage of minorities engaged in biomedical sciences research and other health professions. Among these are: (a) limited exposure of minority students to relevant career opportunities. Because of sparse or non-existant research activity by science faculty at most minority institutions, a number of minority students have concluded that their only option is to teach or become sub-professional workers in industry; (b) minority students who pursue advanced training often find that the absence of a research based science program at their home institutions had put them at a disadvantage. They usually have had little or no training in the use of technologically advanced equipment and little pratical experience in translating scientific hypotheses and laws into useful experiments; and (c) lack of research activity by minority faculty members. Although, many such faculty are well trained, they do not pursue research activity since they are rewarded only for teaching. There is a lack of faciltities and their institutions are ill-equipped to manage research related activities in an efficient manner. In an attempt to address this underrepresentation in the biomedical sciences, the Minority Biomedical Support (MBS) Program was initiated at NIH in 1972. Thirty-eight institutions received MBS grants totaling $2 million during the last six months of that year. Initially, the activities supported focused on student motivation and training an no indirect cost payments were made to the participating institutions. The program has expanded to 80 institutions with a funding level of $18,089,000 in 1980. The focus of activity is on highly meritorius scientific research projects and approximately $4 million of the total is used to pay indirect costs. Indirect costs were first allowed in this program in FY 1979. Since its inception the program has expanded to include several traditional majority institutions with large minority student enrollments and 2 year colleges with more than 50% minority student body population. Some of the eligible majority institutions now in the program have enrollments of up to 10,000 minority students and a demonstrated commitment to educating and training minority students.

In FY 1980, 660 faculty, 1,030 undergraduates and 370 graduate students participated in the programs at 80 institutions. The approximate numbers for FY 1981 are 610 faculty, 950 undergraduate and 340 graduate students participating at 74 institutions.

HISTORY OF THE PROGRAM

The MBS Program in its 9 years of existence is viewed as the most responsive and productive program developed to assist in the discovery of a scientific talent pool heretofore untapped. It was developed from a careful study of the needs by those in the community affected and by appropriate modifications over the years to better serve the public and carry out the mission of the program as it relates to the mission of the NIH.

About 4,000 minority students have participated in the program and another 1,500 are presently being supported. Those that have graduated from the participating institutions have chosen careers in the following pattern:

* About 1,600 have elected to pursue graduate studies leading to the Ph.D. Over 50 have received Ph.D.'s from the 10 minority institutions that have doctoral programs and it is estimated that another 50 have completed Ph.D.'s at institutions not supported by the MBS Program after having participated in MBS as undergraduates.
* About 2,000 MBS participants have pursued health professional careers as doctors, dentists, veterinarians and other health careers. With the current lack of clinical researchers (these individuals have already had one to two years of research experience as undergraduates) this pool of clinicians can be an important source of clinical research personnel.
* The remaining ten percent, who did not choose advanced studies directly, are still in jobs related to health, primarily.

* There are about 1,500 students and 610 faculty at MBS grantee institutions presently engaged in about 500 distinct research projects. These are primarily at institutions not previously engaged in biomedical research.

PRODUCTIVITY

The productivity of the faculty and students as measured by publications and research papers presented at scientific meetings has increased in the following manner. In 1974 only 15% of the faculty published at least one paper. This increased to 34% in 1975, 53% in 1976 and 81% by 1978. Similarly, faculty presentations increased from 29% in 1974 to 82% in 1978. Student presentation of research papers increased from 20% in 1974 to 55 % in 1979. There is a fivefold increase in research productivity by faculty and almost a threefold increase for students. Researchers at the University of Puerto Rico are conducting investigations which ultimately will lead to the development of treatment for two tropical diseases, schistosomiasis and fascioliasis, caused by parasites. The problem is common to Puerto Rico and many other Caribbean countries. A protective antigen has been discovered by these investigators and offers the potential for the development of a vaccine against one or both of these diseases.

At Howard University, an investigator is carrying out research on breast tumor growth. By studying mammary cancer induced in laboratory rats by a carcinogenic agent, he is beginning to delineate the role of hormones and certain hormone inhibitors on the rate of tumor growth. Approximately 40 percent of the mammary carcinoma occuring in American women appears to be hormone dependent; consequently his work has considerable relevance to health. Recently it was demonstrated in this laboratory that the compund CI-628, a female hormone antagonist which competively binds to hormone receptors, induces tumor regression and terminates the synthesis of an important catalyst in tumor cells. They have also shown that another female hormone antagonist, progesterone, results in a blockage of the biological processes involved in tumor development. Both graduate and undergraduate students are involved in the project.

An investigator in the Department of Natural Sciences at Medgar Evers College (City University of New York) has been carrying out biochemical analyses of specific opiate binding sites in the marine mollusc Mytillus edulis. He and collaborators at Albert Einstein College of Medicine were the first to demonstrate that there are opiate binding sites in the pedal ganglia of this inverterbrate. The opiate receptors in the mollusc Mytillus edulis provides a valuable model system for further understanding fundamental aspects of opiate receptor functioning in higher organisms, including man. The investigator chaired a session and described his research at the XXVIII International Congress of Physiological Sciences in Budapest, Hungary in July, 1980. He plans to present new research findings at the International Congress on Comparative Neuropharmacology to be held in Japan in 1981.

COST EFFECTIVENESS OF MBS

During the period of 1974-1980 the MBS has been appropriated 76.3 million dollars to support institutional biomedical research and Minority students. A cost analysis reveals that the MBS has spent on the average of $4500 per undergraduate and $8,800 per graduate student compared to $11,000 spent by other NIH graduate student support. In terms of costs per research project excluding student costs (36.85% of budget) it comes to $25,900 compared to an average of $88,000 for other NIH supported research projects. The cost for MBS supported projects therefore is 1/3 of that of other NIH projects and $2,200 less for each graduate student supported by NIH.

Examining the cost effectiveness of the MBS in another way, during the 1974-1980 period there were a total of 11,348 participants (Faculty, undergraduate and graduate students) leading to a $6,724 spent per participant. This figure reflects only appropriated money and does not include that amount contributed by participating institutes of the NIH. Consequently the average cost for student support (37% of MBS appropriated budget) comes to $3,560 per student.
The MBS program thus is not only the least costly but the only program in the NIH which addresses the need for developing underrepresented minority scientists.

BUDGET REDUCTIONS

As shown in table 1 the proposed rescission of 10,561 million dollars from the 1981 DRR budget still allows for net increases in appropriations in all categories except the MBS. Clinical Research appropriations for instance is 6.7 percent above 1980 while the MBS has been reduced to 7.0 percent below the 1980 appropriations.

Thus the MBS program has been disproportionately reduced by 14% when compared to the Clinical Research or the Biotechnology Component. The Animal Resources and Biomedical Research Support programs remained essentially at the same level as the 1980 figure but still about 7% above the MBS. Though the MBS program makes up only 10.7% of the DRR budget it was the only one receiving a rescission equivalent to 19.3% of the total amount (2,035 out of 10,561 million) cut from the DRR. This is disproportionate.

IMPACT OF MBS BUDGET REDUCTIONS

The 2.035 million dollar reduction in the MBS will have significant effects on the number of Minority institutions training minority students. As a result of this reduction in appropriations, the MBS will not be able to fund six renewal and four new minority institutional applications. This will affect 253 students, 87 faculty members and 79 research projects. It will also not be possible to fund eleven supplemental applications from currently funded institutions. Thus, what appears to be a relatively low reduction of $2 million dollars (.064% of total NIH budget) it will affect a large number of minority students and faculty. A similar reduction in other divisions in the NIH would not have such a dramatic impact.

RECOMMENDATIONS

That this committee restore the $2.035 million (line itemized) to Minority Biomedical Support Program in the DRR. Such a restoration will allow over 340 Minority individuals to not only enter but to also continue in the field of biomedical research by funding 79 research projects. It is difficult to quantitate what this investment in human resources will yield in the future. But it will assure that over 253 individuals can have the opportunity to contribute to the scientific knowledge and manpower of this country.

TABLE 1

BUDGET CHANGES IN DIVISION OF RESEARCH RESOURCES

(Dollars in Thousands)

	1980 ACTUAL	1981 AFTER RESCISSION	PERCENT CHANGE
Clinical Research	56,395	60,148	+ 6.70
Biotechnology Research	17,508	18,908	+ 8.00
Animal Resources	24,680	25,229	+ 2.20
Biomedical Research Support	47,516	47,146	- 0.80
Minority Biomedical Support	18,089	16,817	- 7.03
Direct Operations	3,835	4,545	+ 18.5
Program Management	1,173	1,301	+ 10.9
TOTAL	169,196	174,094*	

*Includes $216,000 for pay raise costs and a proposed rescission of $10,561,000.

STATEMENT OF JAY B. CUTLER, PRESIDENT, COALITION FOR HEALTH FUNDING

Senator SCHMITT. Our next set of witnesses will be Jay B. Cutler, president, Coalition for Health Funding here in Washington D.C., and Harley Dirks, Health Policy Council, from Illinois.

Is Mr. Dirks here? Well, please go ahead Mr. Cutler. We will give you 5 minutes.

Mr. CUTLER. Thank you very much. I will try to summarize the complete text of the statement which I know we shared with this committee, and I will focus on the themes of the statement which express a series of concerns of the coalition.

One is that the concept of the areas of health service deliveries, the assumption by the administration is that State governments, through their departments of health, can now more efficiently manage a series of categorical health programs consolidated into a single block grant. Health services, in this example.

We have no data anywhere that we have been able to find that supports this assumption. We have no legislation that we could review to determine how this has been accomplished. And worse than anything else is the simplistic theory neglects to examine the dismal record of the State health departments in administering the Center for Disease Control's health incentive grant program.

Congress has historically been cutting back in the block grant mechanism because at this time we do not know of any technical expertise held by the States to administer these programs.

It is also very important to recognize that we are talking about a series of very vulnerable people who are going to be hurt because these were congressionally created programs for special populations, targeted for them, the migrant farmworker, urban Indians, mothers, children, adolescents, hypertensives, mentally ill, drug and alcohol abusers, hemophiliacs, and the developmentally disabled.

There are more than 49 million Americans who live in underserved areas. They lack access to necessary health services on account of geographic or financial factors. The value of these programs, in terms of effectiveness, has been demonstrated time and time again.

Another major concern is the dismay and shock by the cutback in research, the area of knowledge development. The President's proposal takes a look, for example, at ADAMHA, and has a decision that really does not provide any equity between the way biomedical research is conducted and the research that is conducted at the ADAMHA.

We are deeply concerned that this in fact will do nothing more than perpetuate stigma, fear and misunderstanding of mental illness, alcoholism, and drug addiction. Other principal reductions include within NIH and in ADAMHA, reductions in research training.

Any reduction in this already modest Federal commitment to biomedical behavioral research will jeopardize outstanding gains in the development of new knowledge, achieved over the past three decades.

It is clear to the members of the coalition that if the rate of progress and knowledge development is to be rapid, all appropriate mechanisms from the search for the knowledge through regular research grants and contracts to the training of young investigators must be supported at an adequate level.

We are deeply concerned about the President's proposal to curtail all flexibility institutional support to the health profession schools and schools of nursing, even though this support has already been built into institutional operating budgets.

The fiscal year 1981 rescissions and fiscal year 1982 budget amendments effect a shift in public policy away from this. The membership of the coalition includes all of the major associations of schools of the health profession.

Each member of the association is pleased to provide this committee with detailed justification for Federal support particular to its own institution. Federal financial participation in the education of health manpower must be recognized as essential if we are to attain national objectives, such as increasing the pool of minorities trained for careers of the health professionals and to provide health services and facilities to underserved communities.

We are concerned by the decision to phase out health planning which is critical if we are to do anything not to accelerate new and unneeded capital construction and eliminate driving up costs of health care in the short run.

We are also equally concerned by one last major theme and that is, if we are to rely upon a system of group practice. The concept has been essentially found in the health maintenance organization which has been federally funded and supported and without this support we will not see the growth that we find necessary.

I guess the major concern, Mr. Chairman, is we have seen a cutback without one single piece of analysis that says these programs are not cost effective. We have not seen any analysis that supports why a program has been cut back, but rather just an arbitrary slashing across the board without recognizing the cost effectiveness, not only over the long haul but the importance of what these programs provide to certain vulnerable special populations. Thank you, Mr. Chairman.

Senator SCHMITT. Thank you. You expressed early in your testimony a distrust of the ability of State health programs to function efficiently or presumably, properly.

Do you think that is something we must endure forever or is it something that can be changed?

Mr. CUTLER. I think there are changes that can be made.

I think if we look at the block-grant proposal as it has been developed in its drafting stage, we see a host of nonaccountable measures to the States, in an arena I know fairly well, psychiatric care for the mentally ill, we have developed only in the last Congress a concept of demonstration block grants which rely on a creative Federal, State, and local partnership. It looks at the ability of the State to do it and does it, if you will, on a phase-in basis.

We have a piece of legislation which says, take these programs and transfer them to the States today, and stop every Federal responsibility dead in its tracks.

The way the drafts seem to be written, no accountability for Federal money, authorizes a State to use any portion of those funds, not so much for the service to the population but to be chewed up in their own administrative costs and makes an assumption that a State can do it with no administrative costs.

I think we have to build up the capacity in the States to do it. We have to take a look at each individual State, instead of saying, what is good for New Mexico has to be good for the Nation.

Senator SCHMITT. Don't you think New Mexico's problems are unique to other portions of the country? Isn't that one of the problems with the programs today, that there is a uniqueness between various regions of the country?

Mr. CUTLER. There may be uniqueness but there has to be capacity within the State to provide services to the people.

Senator SCHMITT. In some States that ability seems to have developed, if not locally, sometimes statewide. In other States, it doesn't seem to have done so.

How can we reward success and provide incentives for success where success has not been apparent?

Mr. CUTLER. That comes from the legislative practices and the development of that, but does not make a simplistic answer to say everything goes to the States without making a value judgment of whether they have the capability, where we talk about phasing-in concepts, whether we make a determination that certain programs—your State decided, for instance, that venereal disease should not be treated. That problem is a Federal problem in a way because venereal disease does not stop at a State boundary.

Senator SCHMITT. I agree with you on that, but what about alcoholism? That is not communicable.

Mr. CUTLER. Historically we have seen the States, that is why the Federal Government took a legislative initiative, to find that alcoholism was treated as a criminal justice problem as contrasted to a disease, public health problem.

As a result of that, we have a tendency to bury the cost in the revolving door system of the jails.

Senator SCHMITT. Don't you think we are past that?

Mr. CUTLER. I have no evidence that says we could turn that back to the States and expect a miracle to happen overnight.

Senator SCHMITT. You advocate the support of HMO development. Many HMOs have gotten into financial difficulty.

Continued Federal support might just deepen that exposure to future default. Don't you think we ought to be more selective?

Mr. CUTLER. Yes; I think we should be more careful in our decision-making, but that is not a matter of stopping Federal support. That is a more intelligent look at the information that is presented, a more intelligent decision making apparatus within the Government to decide what should be funded as opposed to giving away money without looking carefully and analyzing carefully.

Senator SCHMITT. We appreciate your testimony. Thank you, sir. Your statement will be included in the record. I take it that Mr. Dirks is not here.

[The statement follows:]

STATEMENT OF JAY B. CUTLER

The Coalition for Health Funding has now seen President Reagan's budget proposals for health and human services programs. Our objections with this budget stem from the drastic funding reductions for several vital federal initiatives and from a set of troubling economic assumptions. We regret to say that this prescribed economic medicine is dangerous to the health of the American people and the much heralded "social safety" net is full of holes. All of us want to do our fair share to achieve economic recovery and none of us enjoy being labelled as selfish. But it is time to speak out against short-sighted cuts in Federal spending; cuts that are packaged as careful analytic thinking to achieve national objectives. When the wrapping came off the package nothing but a meat ax, not a surgeon's scalpel, was revealed. This will not cure, but kill the patient. This hasty cutting of federal support in traditionally cost-effective sectors will ultimately backfire, when the costs of treatment for disease, for hospital stays, for tuition payments for health professions education, and for health insurance premiums rise to unaffordable levels for all Americans. What also bothers the Coalition is that tobacco subsidies, oil depletion allowances, and development of unnecessary water and power projects will not be affected by this "economic recovery package", leaving the poor and the sick to assume the burden of economic sacrifice.

1. In the area of health services delivery, one of the most troubling assumptions is that state governments, through their departments of public health, can more efficiently manage a series of categorical health programs consolidated in a block grant than the federal government presently performs through the individual targeted approach. No data supports this shallow assumption. No legislation in fact has been sent to Congress for review and debate. The Administration simply assumes that a block grant formula will reduce overhead costs because there are "fewer people processing papers". This simiplistic theory evidently neglects to examine the dismal record of state health departments in administering the Center for Disease Control's Health Incentive Grant Program. The reporting of expenditure of federal outlays and programmatic achievements via this block grant mechanism have historically been poor, leading the last three sessions of Congress to slash federal support for 314(d). State public health departments simply do not have at this time the necessary technical expertise to effectively administer this array of complex programs, because they have seldom been held accountable for complex management and reporting functions.

Additionally the individual categorical programs emphasize specific medical and population targets, detailed accountability reports from each state, and constant cost-effective studies. We also do not assume that there will be less bureaucracy at the state level. Including the need for national leadership and visibility, we feel that these are compelling reasons for maintaining the present approach.

Proposed funding for each of these four separate block grants at 75 percent of the fiscal 1981 aggregate level is also devastating. The FY1982 recommendation of $6.8 billion in comparison to the current services level of $9.1 billion for these programs will clearly necessitate substantial reductions and, in some cases, wholesale elimination of existing medical services to the poor and the at-risk populations. These vulnerable groups include migrant farmworkers, urban Indians, mothers, children, and adolescents, hypertensives, the mentally ill, drug and alcohol abusers, hemophiliacs, black lung beneficiaries, and the developmentally disabled. The budget proposal jeopardizes the continued availability of comprehensive high-quality general medical facilities and services to these targeted population sub-groups.

The Administration may be surprised to learn that currently over 49 million Americans live in underserved areas characterized by low physician to population ratios, high infant mortality rates, high poverty, and growing numbers of elderly. These American families frequently lack access to necessary health services, on account of geographic or finanical factors. The value of these programs, in term of effectiveness, is demonstrated by the fact that these millions of Americans rely upon them as their sole source of preventative and therapeutic health care.

2. In the area of knowledge development, the Coalition is shocked with the proposed budget for the support of biomedical and behavioral research. The President has proposed substantial reductions in the intramural and extramural research budgets for mental health, alcohol, and drug abuse. Clinical training is being eliminated, despite the fact that psychiatry has been identified and designated a shortage speciality. This dramatic contraction in the means to pursue new knowledge in these critical fields will doom the most cost effective treatment and preventive measures, and perpetuate the stigma, fear, and misunderstanding of mental illness, alcoholism, and drug addiction.

Proposed fiscal 1982 funding for the 11 National Institutes of Health will not nearly cover projected inflation rates, with real reductions below the current base in new and competing research grants. Principal reductions also include the institutional payments for NIH research training authorized under the National Research Service Award program. These institutional payments are awarded competitively to qualified institutions to develop or enhance research training opportunities at the predoctoral and postdoctoral level. They also provide a variety of institutional settings required for effective research training to assure this nation a broadly trained nucleus of investigators. A reduction in this already modest federal commitment to biomedical and behavioral research will jeopardize the astounding gains in the development of new knowledge during the past three decades resulting in better health and improved productivity for every American. Since two-thirds of all health research being performed in this country is supported by federal dollars, further progress in our understanding of disease and disability requires support of NIH research programs at more reasonable levels. NIH-supported research has discovered ways to cure and prevent disease, improve the quality of life, restore productivity, and in some instances, reduce health care costs to society. The Coalition is opposed to the short-sighted reduction in support for the National Library of Medicine. The NLM compiles and disseminates the most recent scientific literature to academic health science centers, teaching and community hospitals, biomedical research institutions, pharmaceutical and other health related industries. If these institutions were forced to maintain their own comprehensive collections of print and non-print materials, it would eventually result in an overwhelming increase in the costs of health care delivery. It is clear to the members of this Coalition that if the rate of progress in knowledge development is to be rapid, all appropriate mechanisms, from the search for the knowledge through regular researc grants and contracts, to the training of young investigators, must be generously supported.

3. In the health professions, the Coalition vehemently objects to the President's proposal to eliminate all new awards under the National Health Service Corps program and to curtail all flexible institutional support to health professions schools, and schools of nursing, even though this support has been built into institutional operating budgets. FY1981 rescissions and FY1982 budget amendments have been proposed to effect a shift in public policy away from these existing mechanisms. The membership of the Coalition includes all the major associations of schools of the health professions, namely pharmacy, podiatry, osteopathy, veterinary medicine, optometry, dentistry, medicine, public health, allied health, health administration, and nursing. Each member

association is anxious to provide this committee with more detailed justification for federal support to its own institutions. Cutbacks are also proposed in family medicine, physician assistants, nurse practitioner training, student loans, and health education centers, to name only a few.

At the moment, problems of provider location have been highlighted by studies which emphasize the lack of accessibility to health services, at least in part due to manpower shortages, in rural and inner-city areas. The adequacy of the manpower supply in these areas must be a matter of federal concern and under, some circumstances, a federal responsibility. The National Health Service Corps Scholarship program and the programs cited above address this federal responsibility and at the same time provide a modicum of financial assistance to an already limited number of students training for careers in the health professions.

Federal financial participation in the education of health manpower must be further recognized as essential to guarantee the attainment of identified national objectives, such as increasing the pool of minorities trained for careers in the health professions, and providing health services and facilities to previously underserved communities. Greater attention must be paid by the President and OMB to the needs of the institutions which have accepted the responsibility for training health professionals. These training programs are necessarily multi-year in nature and the institutions which provide the education are multi-purpose and complex, especially in their financing. If the Administration expects these institutions to modify their education programs promptly as patterns of health care delivery change, the institutions must be strong enough, both educationally and fiscally, to change directions and reallocate resources. We include in this category institutions training individuals for the rehabilitation of the handicapped and the developmentally disabled. Of all potential sources of financial support, the Coalition feels that the federal government is best equipped to provide this discretionary support, and thereby, assure the schools the capacity for change. An OMB budget request of $120 million, compared to $473 million in fiscal 1981 for health professions education, can have no reasonable justification.

4. The Reagan Administration proposes to phase out the network of 213 local health systems agencies and 57 state health planning and development agencies. This proposal will undoubtedly cost government, as well as consumers, providers, and other payors of health care, substantially more than the $100 million it purports to save. We believe that if accepted, the nation will soon

experience a dramatic acceleration in new and unneeded capital construction of hospital facilities, driving up the cost of health care in the short-run. Extraneous construction and wasteful addition to existing capacity will increase, despite the costly oversupply of beds already extant in most areas of the country. An elimination of the health planning program will also remove from the decision-making process local citizen involvement in determining the shape of their own future health care services.

Local health planning is succeeding at the same time that the Congress is conveying increased responsibilities to the planning process. Through voluntary means and certificate of need review, local HSAs have been able to reduce unneeded new hospital bed construction by 66 percent between 1977 and 1979. Moreover, there are new legislative mandates, which aim to stimulate competitive forces in the marketplace whenever and wherever possible. More recently, the Congress has granted even greater responsibility to health planning agencies in the development of comprehensive mental health systems. Similarly a hospital bed reduction effort has been proposed which would require local health planning agencies to develop specific bed reduction plans. All of these accomplishments run counter to the Administration's claim that health planning has not demonstrated its cost-effectivenes and our membership stands by ready and willing to defend its continuation.

5. As a corollary to the plan to abolish both federal regulation and federal support of competitive delivery systems, the President proposes to eliminate federal subsidies for the development of health maintenance organizations (HMOs). The Reagan proposal calls for a phase-out of the federal grant and loan subsidy program by the end of 1983, maintaining that at this juncture of federal support, HMOs should be financially self-supporting. The Administration also opposes the replenishment of the depleted federal loan fund which is absolutely vital to financially-dependent HMOs in the pipeline.

The Coalition wishes to emphasize that the primary purpose of this program is to encourage the development of an alternative to the present fee-for-delivery system. As a measure of its success, national HMO enrollment has more than doubled since the passage of the original HMO Act of 1973. Close to nine million people are now receiving care from approximately 230 HMOs, over half of which are federally qualified. Proof of the cost effectiveness of this type of delivery system continues to be verified through reports and studies.

Continued federal support is necessary in order to maintain the momentum achieved by the HMO Program to date. It is widely recognized that the federal inititative has been a significant factor in increasing the acceptance of HMOs nationwide as viable providers of health care and increasing both the number of new HMOs and the enrollment in existing HMOs. While modifications in the Program may result during the consideration of the 1981 Amendments, the importance of the federal HMO effort has not diminished.

A specific funding recommendation has been developed for each program in the Public Health Service and some in the Department of Education through a budget hearing process involving our 62 member organizations. A detailed compilation of these recommendations is included in the Coalition for Health Funding FY1982 Funding Recommendations for Federal Health Programs, a copy of which every Member of Congress will receive. The Coalition stands ready to defend its recommendations and would appreciate having the opportunity to work with this committee as you develop your own.

I will be pleased to answer any questions.

MEDICAL LIBRARY ASSOCIATION

Testimony on the Medical Library Assistance Act (PL95-622) to be Included in the Coalition for Health Funding Presentation

Unfortunately, the FY 1982 budget for the National Library of Medicine includes a decrease from $9.8 million to $8.9 million in funding for the Medical Library Assistance Act (MLAA). If this action is taken, Congress will seriously undermine much of the progress achieved in the past decade to develop a cohesive resource sharing network of health sciences libraries. The programs sponsored through the MLAA are responsible for achieving economy of scale in library management of academic health science centers, teaching and community hospitals, biomedical research institutions, pharmaceutical and other health related industries. It is budgetarily impossible for these institutions to provide their libraries with adequate funds to acquire comprehensive collections of print and non-print materials. In fact, if the health field were forced to implement this, it would eventually result in an overwhelming increase in costs to delivery of patient care.

One of the most important cost saving health programs enacted by Congress is the MLAA because it encourages cooperation and resource sharing on a national scale. However, the development of an effective health sciences library network is an immense undertaking. There are over 8,000 health science libraries in the country; many are located in rural areas. Although the MLAA has been previously underfunded, to date it has effectively reached 2,500 libraries. This achievement has already demonstrated its effectiveness. Numerous local and regional consortia have been created to provide health information to practitioners, educators and researchers. The program has provided, resource grants to develop efficient sharing of resources, library staff development and implementation of new technologies in libraries.

Fortunately, the recent impact of the Information Age, has introduced another important mechanism crucial to future economy measures in health libraries. Automation and computerization of library services provide a means to efficiently keep pace with the information explosion and at the same time fight inflation. The recent technological breakthroughs in development of computer systems allows machine management of information and places a limit on rising personnel costs in this labor intensive field. The MLAA's grants and contract program encourages such progressive activities. Therefore, it is critical that funds be restored to the MLAA to continue development of the Regional Medical Library Program; for improvement of Health Sciences Libraries; for research in health communication and information transfer; for training programs in computer technology and information science; and for publications on related health topics. These coordinated MLAA programs meet the information needs of health practitioners, researchers, and teachers, and contribute toward improved patient care and continued progress in biomedical research.

SUBCOMMITTEE RECESS

Senator SCHMITT. The hearing then will be recessed until 1:30 p.m., this afternoon, when we will continue our look at the National Institutes of Health.

[Whereupon, at 11:20 a.m., Tuesday, March 17, the subcommittee was recessed, to reconvene at 1:30 p.m. this same day.]

(AFTERNOON SESSION, 2:15 P.M., TUESDAY, MARCH 17, 1981)

NONDEPARTMENTAL WITNESSES

Senator INOUYE [presiding]. The subcommittee will please come to order.

This afternoon we will conclude public witnesses' testimony in the health area. We will begin with a panel on the National Institute of Aging, the first of five. The other four panels deal with Alcohol, Drug Abuse and Mental Health, Health Resources Administration, Office of the Assistant Secretary for Health, and the Health Care Financing Administration.

To talk about aging programs, Dr. Daniel Fritz is here representing the Association for Gerontology in Higher Education. The other panelist is Janice Caldwell, the executive director of the Gerontological Society of America.

Are the witnesses here?

We have a lighting system here, but I personally am not in favor of little red and green lights going on, so I just assume that you will be considerate of witnesses that may follow you.

So please proceed, sir.

STATEMENT OF DANIEL FRITZ, PUBLIC POLICY COMMITTEE, ASSOCIATION OF GERONTOLOGY IN HIGHER EDUCATION

ACCOMPANIED BY BETTY DOUGLAS, DEPUTY DIRECTOR

Dr. FRITZ. Mr. Chairman and distinguished chairman of the subcommittee, I am Daniel Fritz, acting director of the Center on Aging at the University of Maryland and a member of the Public Policy Committee of the Association for Gerontology in Higher Education. This is referred to as AGHE.

I would like to introduce Betty Douglas, deputy director, accompanying me.

It is a professional membership of over 200 institutes of higher education that conduct research and training in the field of gerontology.

We applaud the administration's support of programs and services to elderly. Secretary of Health and Human Services, Richard Schweiker, has spoken of the budget's social safety net which will maintain our Nation's commitment to protecting and serving those most in need.

He stated that the President's budget proposals would: "Do nothing to deny income support, essential social services, or critical health services to those most in need."

However, we are concerned about budget cuts that are being proposed by the President in the areas of gerontological research and gerontological education and training.

The following testimony is presented on behalf of AGHE concerning the fiscal 1982 appropriation for the National Institute on Aging. I will also briefly speak to the 1982 appropriations for the National Institute on Mental Health's Center on Aging and the Administration on Aging.

The President's budget calls for cuts of 50 percent or more in Federal support for gerontological research and education. AGHE urges the Congress to consider the implications of those budget cuts. Without adequate funding for research and education we will soon create a situation of low-quality programs, ill-administered and poorly staffed services, untrained personnel, and uninformed planning and administration.

We believe that it is shortsighted to provide social and health services for the elderly without providing the research and educational resources to support these services. In short, it is pennywise and pound foolish to eliminate such research and education.

I would like to suggest five reasons why Federal funding for education and research in aging must be maintained at levels at least comparable to those of the recent past.

First, gerontology is a new discipline. The field of gerontology has been able to develop largely through the support of the Federal Government. Such support must not be withdrawn before the field has matured to the extent that it can turn to other sources of assistance.

Second, Federal funding has a significant multiplier effect. Such support has drawn significant State, local, and private resources to aging research and education. Matching funds from non-Federal sources would be significantly reduced when the Federal commitment is withdrawn.

Third, the need to support other services and needs will preclude adequate support for aging research and education by non-Federal sources. Funding for higher education and research is being reduced across the board through the Federal Government and the resources of State, local, and private sectors will be hard pressed to take up the slack.

Fourth, State support for education in general, not to mention gerontological education, is uneven. One simply needs to compare the education budgets of State governments to learn that the goals of education are not equally valued in the State legislatures across this land.

The fifth reason for asking for Federal support is that there seems to be a line of thinking that the private sector will support research and training efforts in lieu of the Federal Government. Yet there is little evidence that the private sector has the capability, the inclination, or the resources to provide the sustained financial support necessary for capacity building of aging research and educational capabilities at educational institutions.

I would like to now specifically comment on the proposed budget for the National Institute on Aging. The President's budget proposes $84 million for the fiscal year 1982 appropriation to the NIA. This represents an increase of $10 million or 12 percent over the fiscal year 1981 budget.

We endorse the administration's support for the NIA and urge Congress to concur in supporting this funding level. Although we had hoped for more, under the present mood of the fiscal austerity we endorse the incremental increases which is a level appropriation will allow. The one exception which we take with the proposed budget is in the area of geriatric training which will be severely affected by the combination of small overall budget increase and the President's fiscal year 1981 rescission of $1.1 million in the NIA clinical training progam.

Therefore, we would like to urge restoration of funds to the NIA geriatric training program.

Now, I would like to just briefly touch on the proposed funding for the National Institute of Mental Health Center on Aging. Proposed reductions in the NIMH budget will cause them to start phasing out research in the area of mental health. By 1983 the NIHM Center on Aging will provide no funding for clincal training and social research. We ask for restoration of funds to the Center on Aging which will make possible the continuation of these important programs.

The fiscal year 1980 budget provided for $90 million in these two areas. The fiscal year 1982 budget proposes a funding level of $52.8 million and the fiscal year 1983 budget will have no provision for NIMH geriatric training and research. We urge whatever budget reductions are necessary that they be gradual and not this drastic.

We want to briefly comment on the proposed budget for the Administration on Aging. The AOA title IV discretionary programs were funded at $45.5 million in fiscal year 1981. The President's proposed budget calls for a cutback of $25 million which is a cut of 56 percent over the previous year. This reduction will all but eliminate AOA's research, career preparation, and inservice training programs.

Our recommendation for the title IV budget is that the level of appropriation be significantly increased over the President's proposed level. We are not recommending specific amounts. On the other hand, if it is necessary to cut back, we urge that Congress gradually scale back appropriations for the title IV program rather than make the drastic changes being suggested.

Finally, AGHE is opposed to proposed consolidation of the budget. We urge that Congress restore categorical funding or research training and multidisciplinary centers within title IV discretionary budget.

Thank you for this opportunity to comment.

Senator INOUYE. Doctor, I note in your testimony that prevention is more cost effective than therapy. You suggested that by increasing research you may be able to cut down cost of medical care for the aging, which is now about $50 million. Is my conclusion correct that by this research you can cut down the cost of care?

Dr. FRITZ. It is our opinion that there are cases that show that research has been effective in cutting down some of the costs.

Senator INOUYE. Can you name some of them?

Dr. FRITZ. In the case of senile dementia—I think there is a case listed right here in the case of senile dementia.

Senator INOUYE. You are convinced that the savings were sufficiently significant?

Dr. FRITZ. Yes; it is our opinion that we can save some of the costs involved in having people sent to nursing homes by this kind of preventive research.

Senator INOUYE. Any other area that you would like to touch upon? Possible savings as a result of research? I am asking these questions because as you are well aware we in the Congress are not at all expert on anything in this area, and oftentimes colleagues would ask what have we bought for this dollar. And I'm trying to solicit from you what have we bought for this dollar.

Dr. FRITZ. I am not prepared at this time to give you specific examples. I will be glad to give you some additional testimony.

Senator INOUYE. I think it would be helpful.

Dr. FRITZ. Other than the one included here, the senile dementia?

Ms. DOUGLAS. May I suggest another example is given on page 2, where we talk about some of the myths of aging that have been exposed by social research? One example is that it was a myth of poll makers and general public that families in our modern mobile society abandon older members. So therefore, an increase in nursing homes and an increase in institutionalization is therefore to be the wave of the future.

Social researchers have exposed that myth and have shown that that in fact is not the case. Only 5 percent of the elderly population are institutionalized and this percentage is not increasing. The people who are in nursing homes are composed of about 50 percent who are women who have outlived their husbands and who have no children. And who have no other sources of support.

The vast majority of the elderly are living independently in their own homes, and are being cared for if they are frail by their families in noninstitutionalized settings. Because of the findings of social research, therefore, the thrust of social services is to enable the elderly to maintain their independence to assist families to care for their elders in a variety of ways far less costly and more humane than institutionalization.

This is only one of the examples that we could come up with to show how social research and health research has made an impact on the kind of services that are being provided for the overpopulation.

Senator INOUYE. Dr. Fritz, if you will provide this committee with additional information, it would be very helpful. May I now call upon Dr. Caldwell?

STATEMENT OF JANICE M. CALDWELL, EXECUTIVE DIRECTOR, THE GERONTOLOGICAL SOCIETY OF AMERICA

Dr. CALDWELL. Yes; Mr. Chairman and members of the committee—I am Janice Caldwell, executive director of the Gerontological Society of America. I am here on behalf of our nearly 6,000 members who are scientists, researchers, teachers, practitioners, clinicians, planners, and administrators dedicated to understanding the phenomenon of human aging and advancing that understanding through research and education. We are grateful for the opportunity to present our views to you here today.

Other witnesses have, I'm sure, reminded you of the statistics that indicate our country's most long-range and personal challenge. We are all getting older. This fact of American life must begin to inform all aspects of our current spending and future planning.

The Gerontological Society's particular concern in this area is research and education. The budget proposals which we have reviewed reveal an appalling lack of appreciation for the benefits of Government-sponsored research and training. In this effort to reduce Federal spending, the budgeteers have forgotten an important truth, that new knowledge gained through research is the ultimate cost containment device.

Senator INOUYE. May I interrupt at that point?

Dr. CALDWELL. Certainly.

Senator INOUYE. Will you also provide this committee with how money has been saved as a result of research?

Dr. CALDWELL. I can give you the anecdotal example I have coming up in my testimony and then at the end I can add yet another, all right?

Senator INOUYE. Fine.

Dr. CALDWELL. Probably everyone in this room can remember what a threat polio was only 30 years ago.

Every summer, we would hear reports about the number of children who had fallen victim. Each of us knew some child who was not going to return to school in the fall.

Government-funded research finally ended that terror, and ultimately saved millions of dollars in programs that would have been needed to remedy the ravages of that disease if it had gone unchecked. We here today are the beneficiaries of that Government investment of not so very long ago.

Thanks to research, most of the virulent communicable diseases of the past have been eradicated. The challenges of our generation take the form of chronic conditions.

And the most prevalent chronic condition today—one in which every one of us has a personal stake—is aging.

It would be fantastic to suggest its eradication but research can unlock the secrets of the process. Only by understanding the process can we know the appropriate intervention points for prevention, treatment, and providing responsive types of services.

Basic research in aging may now be at a watershed. In the 6 years since its inception, the National Institute on Aging has legitimized research in the biological aspects of aging.

Their findings are finally suggesting patterns of information that should provide direction for the next round of researchable questions. Failure to provide financial support for these efforts now will deny us the future benefits of such work, as well as snuff out the continuation of worthwhile work currently underway.

Here I could digress and speak of the example of osteoporosis which—I am not a physician but—I understand that that is a condition that affects the bones and make them brittle. One of the most common causes of hospitalization among older people is broken hips and bones which very, very often takes a long time for convalescence; and you are talking about high hospital bills and extended-care bills and convalescent activities.

If we could find ways to strengthen older persons' bones, and prevent that kind of condition from developing, I suspect we could save millions of dollars on just that one particular instance of chronic condition.

In addition to basic research, we must invest more in operations research. I borrow this term from the corporate field because I think it's a terrible lack in our health care system today. This country spent $245 million, or 9.5 percent of the GNP on health care, in just 1980. Less than one-half of 1 percent of that amount was spent on research aimed at improving how we spend that colossal sum of money. The research and demonstration programs in the Department of Health and Human Services are the closest that the Department comes to operations research in the aging field.

They are localized in the Administration on Aging, Bureau of Health Manpower, National Institute on Mental Health, and the Health Care Financing Administation. And yet, all of these programs have been cut in this proposed budget by more than 50 percent.

The administration's stated belief that research and training should be the outgrowth of industry need is valid in many arenas. It is not totally transferrable to the health services delivery system, however. Providing community social services programs to the elderly can never be comparable to an airline that decides to offer service on a new route. If it does not turn a profit, the airline will simply discontinue the service. Entirely different criteria must be used to determine the success of a community program for the elderly.

The question is, Is it unrealistic and inefficient to expect every local jurisdiction to reinvent the wheel? Only with Federal Government setting national research agendas, supported with sufficient dollars, can we expect to have an orchestrated system of service delivery for our older Americans.

Availability of services, access to those services, and services provided by adequately trained professionals is the least we can promise ourselves and all our aging Americans.

I will end my remarks by showing you some tangible proofs of previous investments in research. Here are just some samples of what Government dollars have purchased for us. In front of me there are textbooks which have been used in hundreds of universities to train thousands of students in the biological and social aspects of aging.

Each one of these books, some now in their second and third printings, were funded in whole or in part by training or research grants from the Department of Health and Human Services.

These are reports of the National Journal, that tell of several successful conferences that were cosponsored by the Xerox Corp., on the economics of aging.

As you look through the list of speakers, you will find it is dominated by researchers who were working in federally funded policy research centers.

The President's Commission on Pension Policy, which I have a copy of the report, whose recommendations have heavily influenced the current proposals on social security, includes also experts and researchers whose work has been funded over the years by Government research grants.

This is true of other Presidents' commissions; for example, the one on the national agenda for the 1980's.

When Congress itself holds hearings on services to the aged, pension and retirement planning, or in this case, one on work after the sixties, what are the options for the eighties, they do recognize the unique contributions of researchers and practitioners who received support from Federal funding sources. These reports are full of testimony based on facts and findings which are the direct result of Government-sponsored research.

Mr. Chairman, the Gerontological Society of America was founded nearly 40 years ago on the strong belief that the products of research and education enhance the lives of older Americans. Our commitment has not diminished to this day.

We urge the members of this committee to attack the problem of inflation as you construct the budget for 1982, but do not be taken in by the idea that research and training are luxuries. They are necessities for today and even more for our future.

Senator INOUYE. I thank you. Without objection, the full text of the statements of the two witnesses will be made part of the record.

[The statements follow:]

STATEMENT OF DAN FRITZ, PH. D.

Chairman Schmitt and distinguished members of the Subcommittee, I am Dr. Dan Fritz, Acting Director of the Center on Aging at the University of Maryland and member of the Public Policy Committee of the Association for Gerontology in Higher Education (AGHE). The following testimony is presented on behalf of AGHE concerning Fiscal 1982 appropriations for the National Institute on Aging. I will also speak briefly to the FY 1982 appropriations for the National Institute on Mental Health Center on Aging and the Administration on Aging.

The Association for Gerontology in Higher Education is a professional membership association of over 200 institutions of higher education that conduct research and provide education and training in the field of gerontology. AGHE is addressing the challenges involved in the development of knowledge and manpower required to address the legitimate needs of our nation's growing older population.

The elderly are the fastest growing age group in our society. They will increase from 25 million at present to over 50 million by the year 2030. Today they comprise 11 percent of the population; by the early decades of the 21st century they will comprise 20 percent of the population. Over the next several decades our nation must be prepared to address the needs, the potential, and the problems of this growing segment. We must as a nation expand our knowledge about the aging process and improve the quality of services to the elderly so that the enormous potential of the older population can be used to the benefit of society, so that problems can be avoided before they create a drain on the economy and a decrease in the quality of life.

We applaud this Administration's support of programs and services to the elderly. Secretary of Health and Human Services Richard Schweiker has spoken of the budget's "social safety net" which will maintain our nation's commitment to protecting and serving those most in need. He has stated that the President's budget proposals would "do nothing to deny income support, essential social services or critical health services to those most in need."

Mr. Chairman and members of the Subcommittee, there are two essential social and health-related programs which are being drastically and irrevocably damaged by the President's budget. I am here to speak to these areas today. They are geronotlogical research and gerontological education and training.

At a time in our nation's development when we are faced with a burgeoning older population we are blessed with a rapidly developing field of gerontology. Gerontological research is providing us with answers about appropriate and effective social services for older people and about the treatment of the chronic impairments of old age. I quote Dr. Robert Butler, Director of the National Institute on Aging:

> We need resources--specialized centers, animal models, human populations, opportunities for research training. We need to discover new knowledge that will assist us in maintaining healthy middle years of life and to sharply reduce protracted economic, physical and emotional dependency....We live in a period in which the disciplined imagination of science must be promoted. Both the governmental and private sectors must take risks in supporting adventures of the mind resulting in new knowledge that breaks through stagnation and serves all--and, in the end, is likely to save us money![1]

Gerontological research has helped dispel an enormous array of myths about the aging process and has therefore made it possible for social and health service providers to design programs that address real, not fictitious, needs of the older population.

Let me give one example. One myth of policy makers and the general public was that families in our modern, mobile society abandon older members. It was believed that an increase in nursing homes and increased institutionalization of the elderly were the wave of the future. Furthermore, it was believed that liberalization of home care benefits under Medicare and Medicaid would result in further abandonment and a veritable raid upon the federal treasury. Social research by gerontologists has shown that these assumptions simply are incorrect. Research has demonstrated that only 5 percent of the elderly population are institutionalized and that this percentage is not increasing. About 50 percent of nursing home residents have no families, about 75 percent are women who have outlived their husbands or who have no children. The vast majority of the elderly are living independently in their own homes; the vast majority of the frail elderly are cared for by their families in non-institutionalized settings. Today, as a result of the dispelling of these myths, the thrust of social services to the older population is to enable the elderly to maintain their independence and to assist families to care for their elders in a variety of ways far less costly and more humanely than institutionalization.

In addition to the role of research, the second area of concern in this testimony is the career education of persons entering the field of aging services and the in-service training of those already employed. As the size of the aging population has increased, as the number of programs serving the elderly as grown, there has been an enormous demand for personnel trained to work with older persons. This demand has come not only from specialized programs serving primarily or exclusively the older population, but also from organizations and institutions serving the general population. These persons educated in gerontology and trained in the aging process are able to effectively plan, administer, and evaluate a vast array of services and programs provided for the general population and specifically the aged in both the public and private sector.

The President's budget calls for cuts of 50 percent or more in federal support for gerontological research and education. The Association for Gerontology in Higher Education urges the Congress to consider the implications of these budget cuts. Without adequate funding for research and education, we will soon create a situation of low quality programs, ill administered and poorly staffed services, untrained personnel, uninformed planning and administration. We believe that it is short-sighted to provide social and health services for the elderly--Mr. Schweiker's "social safety net"--without providing the research and educational resources to support these services. It is penny-wise and pound-foolish to effectively eliminate research and education which undergird the fastest growing segment of social and health service in our country.

I would like now to address the importance of federal funding for gerontological education and research. Federal funding must be viewed as a complement to financial resources available from the state and local government and from the private sector. Even as federal funding must not be considered an alternative to other sources of funding, neither must the converse be the case: state and private support for gerontological education and research cannot be a substitute for federal funding. I suggest five reasons why federal funding for education and research in aging must be maintained at levels at least comparable to those of the recent past.

(1) Gerontology is a new discipline. It is not well established, well recognized, or universally appreciated. Only since the 1930's has gerontological research been a reality, and it has blossomed only within the past twenty years. Education in gerontology began to achieve recognition in the late 1950's within the large universities. The field of gerontology has been able to develop largely through the support of the federal government. That support must not be withdrawn before the field has matured to the extent that it can turn to other sources of assistance. Only in recent years have some universities been willing to commit "hard" dollars to gerontology programs. The federal support must not be withdrawn until the field has matured enough to attract solid financial support from alternative sources.

(2) Federal funding has a significant multiplier effect, in that federal support has drawn significant state, local and private resources to aging research and education. Conversely, reductions in federal support have ramifications far beyond the absolute dollar reductions in terms of these non-federal commitments. The matching funds made available from non-federal sources will be significantly reduced when the federal commitment is withdrawn.

(3) The economy of resources will simply preclude adequate support of research and education by non-federal sources. Funding for higher education and research is being reduced across the board throughout the federal government, and the resources of state, local and private sectors will be hard-pressed to meet the demands to take up the slack. If state, local and private funds are increasingly called upon to provide services in lieu of federal support, those resources will be taxed beyond their capacity to meet the needs of the expanding aging field.

(4) There is a vast unevenness in state support for education in general, not to mention gerontological education. One simply needs to compare the education budgets of state governments to learn that the goals of education are not equally valued in the state legislatures across this land. Specialized education is at even greater disadvantage than general education in competing for the endorsements of state budget committees. The education lobby is feeble when pitted

against the advocacy efforts of industry and business and some of the professions. Federal funding of gerontological education and research has at least partially shielded the field from the vicissitudes of state politics and has not made educational and research opportunities completely at the mercy of sectional biases.

(5) There is enormous faith within the current Administration in the capacity of the private sector to support research and training efforts in lieu of the federal government. Yet we see little evidence that the private sector has the capacity, the inclination or the resources to provide the sustained financial support necessary for the capacity-building of educational institutions. Steady, uninterrupted, incrementally increasing provision of funding is essential. Quality educational institutions and research centers cannot engage in curriculum and faculty development, student recruitment, data collection, analysis and dissemination, without some guarantee of secure funding over several years. The burden of this steady funding cannot rest solely on the non-federal sector. The effect of dramatic financial starts and stops on the development of educational institutions is devastating.

The National Institute on Aging. I turn now to address specifically the budget of the NIA. The President's budget calls for an $84 million appropriation to NIA, an increase of $10 million--or 12 percent--over the FY 1981 budget. We endorse the administration's support of NIA and urge the Senate to concur in supporting this funding level. The proposed appropriation will simply enable NIA to meet the impact of inflation and to continue the operation of the Institute in a no-growth status. Although we would have hoped for more, under the present mood of fiscal austerity, we endorse the incremental increase which this level of appropriation will allow.

NIA's FY 1981 budget for extra-mural research grants is $48.7 million. Forty-nine million dollars for NIA research is a small sum when compared with approximately $50 billion spent annually for health care of the aged.

Why is geriatric research so urgently needed? We do not know yet the exact causes of cardiovascular disease, arthritis, stroke, diabetes, cancer, osteoporosis, or senile dementia. We do not know whether social factors, biological or environmental factors predominate. Typically, the elderly receive treatments aimed at palliating or moderating the course of disease, but rarely are cures produced. We know little about preventing any of these diseases. The situation in treatment of the elderly is analogous to the treatment of children for polio in the days before the oral vaccine. The half-way technologies disappeared because the disease disappeared. Who would argue that money would have been better spent treating polio than in researching the causes of the disease and eliminating it? Both were necessary.

In the case of senile dementia we are in a stage analogous to the pre-viral identification stage for polio. With measures to prevent or treat senile dementia before they require institutionalization, there could be substantial cost savings as well as humanitarian rewards. Consider that more than $18 billion a year is spent on nursing home care for the elderly, and that an estimated half of this is spent on individuals with dementia or other serious mental illness. Solutions to the management or elimination of geriatic diseases will have dramatic impact on health care costs. As research provides solutions, the demands placed on the health service system will change.

The geriatric training within NIA will not fare as well as research in the proposed budget. President Reagan's rescission of $2.2 million in FY 1981 from the NIA budget will dramatically impact the geriatric training program. From a $2.9 million training budget will be taken $1.1 million in the current fiscal year, resulting in a loss of fifteen trainees. The overhead costs on institutional awards will be eliminated as will the institutional allowance which covers medical insurance, travel, and supplies. Only the basic stipends to the trainees will remain. It is crucial that there be federal support through the budget of NIA to train physicians in geriatrics who will better serve the unique health needs of the elderly. As research and service improve, the health of the aged will improve. We are already profiting by past investments in research and training in geriatrics. To continue making these investments does not amount to taking away services from today's vulnerable elderly who currently benefit from past investments. We urge your commitment to the NIA budget.

The National Institute of Mental Health Center on Aging. AGHE is particularly concerned about the Administration's FY 1982 requests for the NIMH Center on Aging because it calls for a phasing out of social research while maintaining basic and applied research in the areas of the neuro-sciences, behavioral sciences, psychopharmacology, clinical investigation and evaluation of the treatments and services for the mentally ill. The research training program is phasing out support for training in the investigation of social problems, and it will cease to fund institutional and the indirect cost on awards made after July 1, 1981 Clinical training will be gradually phased out in 1981 and 1982 and eliminated entirely in 1983.

The FY 1980 budget provided for $90 million in clinical and research training. The FY 1982 budget provides for $52.8 million; the FY 1983 is proposed to allow no funding in these areas.

These drastic funding reductions will make it difficult for many student committed to careers in the mental health professions to pursue their studies. It will undoubtedly result in a dramatic reduction in the level of trained manpower to address the mental health problems of our nations elderly. Such cuts will particularly affect the education of minority students to fill mental health positions, because often such students come from backgrounds that make it imperative that they receive such clinical training support.

Of all age groups, the elderly have the greatest prevalence of mental disorders, the highest rate of suicide, the greatest risk for institutionalization, the highest degree of drug use and misuse, with the least access to mental health services. Unfortunately many of the myths about old age are shared by large numbers of health and mental health practitioners. The geriatric research and training provided by the Center of Aging is one small but important vehicle for training doctors in the proper treatment of mental illness among the aged population.

The mental health problems of old age create serious economic consequences for the society. Alternatives must be found to expensive institutionalization which costs an average of $12-18,000 per year per institutionalized older American. Such alternatives are lodged in the prevention and early treatment of depression and other symptoms of mental disorder and in the development of community support system.

The major hope for progress in the field of mental health for the aged will have to come from congressional support for the type of training and research programs that have been supported by NIMH in the past and are in jeopardy today. If the nation is to adequately address the mental health needs of the growing older population in a cost effective way, it is imperative that the Congress significantly reduce the budget cuts called for by the Administration.

The Administration on Aging. AGHE is concerned with the President's budget for the Administration on Aging. The programs funded under Title IV of the Older Americans Act will be devastated by the proposed cutback of 56 percent over FY 1981 funding levels. From 1975-1980 there was a gradual increase in appropriations for gerontological education, training, and research within AoA, from $23 million to $54.3 million. In FY 1981 there was a 16 percent cut in Title IV appropriations to $45.5 million. President Reagan's budget proposes a $25 million reduction to Title IV, putting the funding back at the 1975 level. This cut, coupled with the effects of inflation over the intervening 7 years, all but wipes out AoA's research, training and education programs.

To be specific, the education and training program will have a budget of approximately $6 million (compared to $17 million in 1980 and $14 million in 1981). In FY 1981 eighty institutions of higher education received support for career preparation in gerontology. A study conducted by Ketron, Inc. of the FY 1977-78 AoA career preparation program provides insight into its scope. That year 58 schools offered over 500 courses in aging, with over 200 degree programs, over 14,000 students enrolled in aging courses that were made possible by career preparation grants. Over 6,000 students from these schools received degrees in gerontology or pursued majors in aging as a part of another academic program. Within a year of graduation 82 percent of the aging degree holders were in aging related jobs.

The Ketron study concluded: "If anything, the resources expended (in the Title IV education program) seemed modest compared with the results achieved.... Thus, hundreds of doctors, nurses, lawyers, architects, librarians, urban planners, management specialists, and practitioners in dozens of other fields became more sensitive to the needs of the elderly and more aware of the aging process because of a very small expenditure of funds."

A specific contribution of the AoA education and training program has been the education of minority students in aging. In 1980 twenty minority institutions received support from AoA's education and training funds. The proposed budget cuts will have immediate impact on the continuation of these programs. Only within the past five years have minority academic instituions begun to develop substantial programs in gerontological training and research. Many of these schools will not be able to continue these programs without the seed money provided by the federal budget. Minority elderly are living longer than they were only a few years ago; it is imperative to have qualified minority professionals who are committed to working with and in behalf of the minority elderly.

The AoA funded state education and training program provides funds to support nondegree, continuing education and inservice training for state, area, and service provider personnel. In 1979 almost 46,000 people were trained, including 27,000 service providers, 4,400 volunteers, and 10,000 people employed by state and area agencies. The result of the proposed budget cuts to the AoA's Title IV discretionary program will be that the state education and training program will have to share approximately $6 million with the career preparation program. Neither will be able to operate beyond a subsistance level.

In 1981 the largest cut in Title IV programs was suffered by research, with a 29 percent reduction in funding. The probability that research will be cut by an additional 50 percent or more in FY 1982 to possibly $3 million or less effectively eliminates all federal research that relates to service delivery strategies and the social and health problems of aging. Title IV research is particularly important in that it is the primary source of basic knowledge required by AoA in carrying out the legislative mandates of the Older Americans Act.

The Multidisciplinary Centers on Aging funded under Title IV, including Long Term Care Centers and National Policy Study Centers, bring together specialists from a wide range of disciplines to develop comprehensive perspectives on specific problems of the elderly in order to improve programmatic and legislative solutions. Since each center focuses on a single problem area (income, housing, health) with their multiple perspectives and aggregate knowledge, these centers can begin to provide answers to critical social policy questions in aging. There are currently six National Policy Study Centers and sixteen Long Term Care Centers with a total funding of $3 million. If these centers suffer cutbacks of 50 percent or more, there is serious question as to the possibility of their continuation.

Our recommendation for the AoA Title IV budget is that the level of appropriation be significantly increased over the President's proposed level. We are not recommending specific amounts, but rather urge Congress to provide, if necessary, for a gradual scaling down of appropriations for the Title IV discretionary programs rather than to wield a death blow to the entire federal support for the research and education that undergirds our nation's social and health services for the elderly.

We also oppose the consolidation of the Title IV budget and urge Congress to restore categorical funding of research, training, education, and multi-disciplinary centers within Title IV discretionary budget. Each program category is necessary. To consolidate all into one budget category would jeopardize their existence and would tend to pit one against the other in a battle over scarce resources. The roles played by research, career preparation, inservice training, and by the gerontology centers and special projects are vital and discrete and should have some protection from the consolidation of a bare-bones budget.

In conclusion, the needs and problems of the elderly will not be reduced nor come to a standstill to accommodate budget cuts in an attempt to balance the federal budget. When the needs of any segment of the population are temporarily denied, a larger price is paid at a future time. Prevention is more cost-effective than therapy. Money expended today to prevent problems of tomorrow's elderly will be less costly than dealing with those unsolved problems in the future. We urge you to restore adequate funding for gerontological education and research to the FY 1982 budget. We must not forfeit our chances of finding future solutions to the human and economic needs of the aged because of the relatively small impact these cuts will have on attempts to balance the federal budget.

June 16, 1981

Senator Mark Hatfield
U.S. Senate Appropriations Committee
Washington, DC 20510

Dear Senator Hatfield:

In March 1981 Dr. Daniel Fritz testified before the Senate Appropriations Sub-committee on Labor, HHS, and Education. He spoke on behalf of the Association for Gerontology in Higher Education for the budgets of the Administration on Aging, the Center on Aging of the NIMH, and the National Institute on Aging. Specifically, Dr. Fritz was calling for increased appropriations for gerontological research and education. A copy of his testimony is enclosed.

In the course of his testimony, Senator Inouye requested that he be provided with some concrete examples of ways in which aging research was cost-effective and beneficialto our society. We provided the Senator some examples at the time, but he requested others. We have prepared a few examples of such research, and they are enclosed for your information.

We hope that this information will be useful as the Senate deliberates that FY 1982 budget. The proposed cut of over 50% for gerontological research and training in the Administration on Aging is the largest budget cut suffered in the Department of Health and Human Services. This drastic reduction will have disastrous effects on the research and education programs which underlie the planning and delivery of direct services to older Americans.

We hope that these research examples will give some insight to you and your colleagues into the key role which gerontological research and training play in improving the quality of life of America's elderly in cost-effective ways.

Sincerely yours,

Elizabeth B. Douglass

Elizabeth B. Douglass
Executive Director

ELDER ABUSE: A HIDDEN TERROR FOR THE AGED

The physical and mental abuse of the elderly population of the United States is a widespread problem which only within the past few years has come to light. In 1980 a research project completed at the Institute of Gerontology at the University of Michigan documented the extent and severity of abuse of the elderly.

The project has been widely used by policymakers, practitioners and community leaders in developing legislation dealing with elder abuse, in establishing community programs to serve these battered people, and in publicizing the heretofore unknown victimization of many older people.

The research on elder abuse at the University of Michigan was funded by the Administration on Aging and is an example of ways in which aging research has far-ranging implications for the lives of older Americans.

Gerontological Research Institute. The Projects and Uses of Research Sponsored by the Administration on Aging, by Kristina Peterson and Deborah Leinbach, American Institutes for Research, Washington, DC, 1981.

IMPROVED ARCHITECTURAL DESIGNS INCREASE LIVEABILITY OF NURSING HOMES

The living patterns and preferences of nursing home patients do not usually affect the design of nursing homes, a fact which leads to dissatisfaction, discomfort, and frustration among the residents of these homes.

A study at MIT discovered that (1) the elderly prefer separate rooms to large, multi-purpose rooms, (2) they have more furniture than other people, (3) their needs sometimes require two bedrooms, and (4) they prefer small community rooms.

As a result of this study the U.S. Department of Housing and Urban Development changed its floorplan designs of nursing homes. The state of Massachusetts now requires that 5-8 percent of all HUD-subsidized housing units contain two bedrooms. Commercial architects have likewise modified their designs for elderly housing in the Boston area.

Such research by gerontologists sponsored by the Administration on Aging lead to changes in policy and service delivery that mean an improved quality of life for this nation's elderly.

Sandra Howell, Massachusetts Institute of Technology. See paper by Kristina Peterson and Deborah Leinbach, "Gerontological Research Institute: The Products and Uses of Research Sponsored by the Administration on AGing", Washington, DC: American Institutes for Research, 1981.

PROPER DIAGNOSIS OF MENTAL ILLNESS AMONG THE ELDERLY SAVES MONEY

As many as 35 percent of senile dementia patients are mis-diagnosed, suffering instead from treatable emotional disorders. Money is wasted on inappropriate and costly treatment caused by mis-diagnosis.

Proper diagnosis and outpatient care can permit the older person to remain independent in the community. Psychological and psychiatric research has proven highly productive with regard to the diagnosis of the following mental and emotional difficulties among the aged:

- depression - Eisdorfer, C., Cohen, D., and Veith, R.: The Psychopathy of Aging. (Monograph) Kalamazoo: Scope Publications, 1980.
- paranoia - Kaplan, O., The Psychopathology of Aging. 1980.
- dementia - Busse, E. The Duke Longitudinal Study of Senile Dementia, in Katzman, R., Terry, R. and Bick, K., eds., Alzheimer's Disease: Senile Dementia and Related Disorders. 1978.
- anxiety, neuroses, and sleep discorder - Birren, J. and Sloane, R.B.: The Handbook of Mental Health and Aging. 1980.

Mental health professionals have never had the resources adequate to conduct research and training in the area of proper diagnosis of mental and emotional problems of the elderly. Research sponsored by the National Institute on Aging and the Center on Aging of the National Institute on Mental Health is crucial to improved diagnosis and treatment of the emotionally impaired elderly.

IMPROVED THERAPY FOR NURSING HOME RESIDENTS REDUCES THE COST OF CARE AND TREATMENT

Over $7 billion is spent in caring for nursing home patients annually in the United States. Gerontological research is providing insight into ways of reducing the cost of institutionalization of the one million residents of nursing homes.

By using combinations of behavioral and physical therapy, the staffs of nursing homes are able to increase the capacity of nursing home patients to care for themselves. Often the emotions and behaviors associated with pain can become greater hindrances to functioning than the disabilities themselves. The need for expensive medication and constant nursing and custodial supervision can be substantially reduced when the re-establishment of selfcare among such nursing home residents is accomplished.

Research into the improved therapy of emotionally and mentally ill elderly is conducted by the Center on Aging of the National Institute on Mental Health and by universities funded by grants from the NIMH Center on Aging.

William S. Richards and Jeffrey L. Thorpe, "Behavioral Approaches to the Problems of Later Life," and Martha Storandt, Ilene Siegler, and Merrill Elias (eds.), The Clinical Psychology of Aging.

IMPROVED HOME CARE SERVICES CAN PREVENT INSTITUTIONALIZATION OF THE ELDERLY

Increasing the quality and the quantity of home-delivered services would enable the frail elderly to be cared for within their own homes, thus avoiding institutionalization.

In a gerontological research study, it was found that neither the mental health services nor the physical health services provided by nursing homes and other instituitions were any more adequate than those being provided for older persons living independently at home. The low cost services provided through home health and homemaker services provided the same quality of care for much less money than institutionalization of the elderly.

The discovery of the mental, physical, social, and financial benefits of home-delivered services is a helpful deterrent to the trend toward institutionalization of older people when they become incapable of living totally independently in their own homes.

Research funded through the Administration on Aging enables more effective delivery and design of services to be provided to the frail elderly.

M. A. Smyer, "Differential Usage and Differential Affects of Services for Impaired Elderly," Center Reports on Advances in Research, The Duke University Center for the Study of Aging and Human Development, I, 4, Winter 1977.

"LIFELINE" EMERGENCY RESPONSE SYSTEM ENABLES FRAIL ELDERLY TO LIVE INDEPENDENTLY IN THEIR OWN HOMES

The lifeline emergency response system is a practical, workable service that delays or prevents costly institutionalization of the frail elderly. The system, developed by gerontological researchers, makes possible the continued independent living of elderly persons who would otherwise be institutionalized.

The lifeline system makes it possible for frail elderly to receive immediate attention in the event of medical or other emergencies. It was discovered that lifeline users felt more comfortable about living alone and more confident about continuing to live independently than did non-users.

For each one day spent in a nursing home by lifeline users, non-users required a 13 day period. For lifeline users who were severely functionally disabled and not socially isolated, each one dollar of lifeline services produced a net savings of $7.19 in total long-term care cost due to reduced institutional and community care.

Gerontological research sponsored by the National Institute on Aging, the National Institute on Mental Health Center on Aging, and the Administration on Aging make possible the development of services which benefit the elderly population and are less costly than the institutionalization of the frail elderly.

Sylvia Sherwood, et al, "A Study of the Effect of an Emergency Alarm - Response System for the Aged: A Final Report to the National Center for Health Services Research," February 1980.

"RELOCATION PREPARATION" PROGRAMS REDUCE COST AND TRAUMA OF HOUSING RELOCATION AMONG FRAIL ELDERLY

Older people are forced to move with increasing frequency when low rent apartments are converted to condominiums, when deteriorating neighborhoods are swept up in urban rehabilitation, and when it is necessary to transfer the frail elderly from one institutional setting to another. Such moved often result in physical and mental deterioration, increased cost in maintaining the frail elderly, and often increased mortality.

A series of research projects have enabled service programs to be developed which emotionally, socially and physically prepare these older people for relocation. Such "relocation preparation" is able to mitigate the effects of residential change. Human discomfort and grief are reduced, costs--both financial and otherwise--are lessened.

M. Powell Lawton, Environment and Aging. See this resource for a report of these research studies.

COMMUNITY TRAINING PROGRAM DELAYS INSTITUTIONALIZATION OF SENILE DEMENTIA PATIENTS

Inexpensive training programs designed to assist families and community service workers maintain elderly senile dementia patients in their own homes could save $5 billion a year in health care costs for the frail elderly.

About 15% of the U.S. population over the age of 65 are in need of total surveillance daily. Only about 5 percent are institutionalized, with the remaining 10 percent being cared for by family or friends in non-institutionalized settings. It costs about $7,000 per year to maintain a nursing home resident; about $2,000 a year in health care costs for the non-institutionalized elderly suffering from senile dementia.*

A program conducted by the Duke University Center for the Study of Aging and Human Development trains the families of senile dementia patients and community social service providers to care for these frail elderly in their homes in order to delay inevitable institutionalization for one year. Billions of dollars a year could be saved if these patients could be maintained in their homes one year longer. Training programs such as this funded by the Administration on Aging, Division of Education and Training, are a wise investment of money and manpower.

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* See Odin W. Anderson, "The Social Strategy of Disease Control: The Case of Senile Dementia" in Clinical Aspects of Alzheimer's Disease and Senile Dementia, edited by Nancy E. Miller and Gene D. Cohen of the NIMH Center on Aging, Raven Press, N.Y., 1981.

MIS-DIAGNOSIS OF MENTAL DISORDERS AMONG ELDERLY RESULTS IN COSTLY AND INAPPROPRIATE INSTITUTIONALIZATION AND TREATMENT

About $1.5 billion now being spent on inappropriate institutionalization and medical care of the elderly in the United States could be saved with proper diagnosis of mental disorders.

It is estimated that about 10 percent of the over-65 years old population have significant intellectual impairment. Of this 10 percent (2.5 million people), about 20 percent have reversible conditions which are caused by overuse of drugs, depression, metabolic or infectious disorders. This means that about 400,000 elderly people in this country now housed and treated as though they have irreversible mental illnesses are suffering from disorders which can indeed be treated and substantially alleviated, if not cured entirely. The impairments they suffer are often mistaken for senile dementia by family and physicians, and the institutionalization of such patients is in most cases unnecessary, inappropriate, expensive and a waste of human resources.

Physicians trained in geriatric medicine are alert to alternative causes of intellectual and emotional impairment in the elderly and are informed about its treatment and prevention. Funding is urgently needed by the National Institute on Aging to provide the research and training needed among the medical profession to make possible appropriate diagnosis and treatment of these mental and emotional impairments among the elderly.

Task Force Sponsored by the National Institute on Aging, "Senility Reconsidered: Treatment Possibilities for Mental Impairment in the Elderly", Journal of the American Medical Association, July 18, 1980, vol. 244, #3.

STATEMENT OF JANICE M. CALDWELL

Mr. Chairman and members of the Committee, I am Janice Caldwell, Executive Director of The Gerontological Society of America. I am here on behalf of our nearly 6000 members who are scientists, researchers, teachers, practitioners, clinicians, planners, and administrators dedicated to understanding the phenomenon of human aging and advancing that understanding through research and education. We are grateful for the opportunity to present our views to you here today.

Other witnesses have, I am sure, reminded you of the statistics that indicate our country's most long-range and personal challenge: we are getting older. This fact of American life must begin to inform all aspects of our current spending and planning. The Gerontological Society's particular concern is the area of research and education.

The Case for Research and Education

The budget proposals which we have reviewed reveal an appalling lack of appreciation for the benefits of government-sponsored research and training. In their efforts to reduce Federal spending, the budgeteers have forgotten that new knowledge gained through research is the ultimate cost containment device. It is the ultimate service to society.

Probably everyone in this room can remember what a threat polio was 30 years ago. Every Summer, the count would swell. We each knew of children who would not return to school in the Fall. Government-funded research finally ended that terror, and ultimately saved millions of dollars in programs that would have been needed to remedy the ravages of that disease if it had gone un-checked. We here today are the beneficiaries of that government investment of not-so-long ago.

Thanks to research, most of the virulent communicable diseases of the past have been eradicated. The challenges of our generation take the form of chronic conditions. And the most prevalent chronic condition today -- one in which every one of us has a personal stake -- is aging. It would be fantastic to suggest its eradication, but research can unlock the secrets of the process. Only by understanding the process can we know the appropriate intervention points for prevention, treatment, and providing responsive types of services.

Basic research in aging may be at a watershed. In the six years since its inception, the National Institute on Aging has legitimized research in the biological aspects of aging. Researchers have been trained with a special emphasis on aging. Their findings are finally suggesting patterns of information that should provide direction for the next round of researchable questions. Failure to provide financial support for these efforts now will deny us the future benefits of such work, as well as snuff out the continuation of worthwhile work currently underway.

In addition to basic research, we must invest more in operations research. This Country spent $244 billion -- or 9.5% of the GNP -- on health care in 1980. Less than half of 1% of that amount was spent on research aimed at improving how we spend that colossal sum of money. The research and demonstration programs in the Department of Health and Human Services are the closest the Department comes to operations research in the aging field. They are localized in the Administration on Aging, Bureau of Health Manpower, National Institute on Mental Health, and the Health Care Financing Administration. And all of these programs have been cut in the proposed budget by more than 50%.

Need for Government-Sponsored Research and Education

The Administration's stated belief that research and training should be the outgrowth of industry-induced need is valid in many arenas. It is not totally transferable to the health services delivery system, however. Providing Community Social Services programs to the elderly, as an example, should not be comparable to an airline offering service on a new route. If the experimental route does not turn a profit, the airline will discontinue the serice. Entirely different criteria, however, must be used to determine the success of a community program for the elderly. The question is: is it unrealistic and inefficient to expect every local jurisdiction to reinvent the wheel? Only with the Federal Government setting national research agendas supported with sufficient dollars can we expect to have an orchestrated system of service delivery for our older Americans. Availability of services, access to those services, and services provided by adequately trained professionals is the least we can promise ourselves and all other aging Americans.

Benefits of Past Government Investments

I will end my remarks by showing you tangible proof of previous investments in research. Here are just samples of what government dollars have purchase for us:

1. These are textbooks which have been used in hundreds of universities to train thousands of students in the biological and social aspects of aging. Each one of these books, some now in their second and third editions, were funded in whole or in part by training or research grants from the Department of HHS.

2. These National Journal Reports tell of several very successful conferences funded by the Xerox Corporation on the Economics of Aging. The list of speakers is dominated by researchers working in Federally-funded policy research centers.

3. The President's Commission on Pension Policy, whose recommendations have heavily influenced current proposals on Social Security, includes experts and researchers whose work has been funded over the years by government research grants. This is true of most President's Commissions like this one for a National Agenda for the 80's.

4. When Congress holds hearings on services to the aged, pension and retirement planning, or in this case "Work After 65" - Hearings of the Senate Committee on Aging, it recognizes the unique contributions of researchers and practitioners who have received support from Federal funding sources. These reports are full of testimony based on facts and findings which are the direct result of government-sponsored research.

Mr. Chairman, The Gerontological Society of America was founded nearly 40 years ago on the strong belief that the products of research and education enhance the lives of older people. Our commitment has not diminished to this day. We urge the members of this Committee to attack the problem of inflation as you construct the budget for 1982. But do not be taken in by the idea that research and training are luxuries. They are necessities for today, and even more, an investment in our future.

Thank you.

RECOMMENDATIONS

I. Contrary to what the Department of Health and Human Services statement on the proposed budget suggests, Research and Demonstration funds are not simply cut back to their 1980 level. In some programs, the Administration on Aging Title IV, for example, this would represent an increase which the actual line item of the budget does not verify. In fact, the 1982 proposal of Title IV represents a 50% cut from 1981 which is, in fact, a reduction of 60% from 1980. Taken from this perspective, we would be satisfied to have the 1980 level of funding restored to all DHHS Research and Demonstration programs.

II. With respect to the Administration on Aging's programs:
   A. Restore Title IV funds to at least 1981 levels.
   B. Ensure continuation funds for all projects currently funded.
   C. Maintain categorical funding in Title IV (A, B, C, etc.) to guarantee emphasis on needed areas of research and training.

STATEMENT OF TERENCE ROGER, DEAN, JOHN A. BURNS SCHOOL OF MEDICINE, UNIVERSITY OF HAWAII

Senator INOUYE. At this time I wish to call Dean Terence Rogers to testify on unique problems of Micronesia.

Mr. ROGERS. I'm Dean Terence Rogers of the John A. Burns School of Medicine, University of Hawaii. The purpose of our testimony today is to draw attention to the fact that in the Central Pacific, there are American territories in which the physical quality of life resembles that of the so-called Third World, and this is especially true in primary and preventive health care.

The Trust Territory of the Pacific Islands, also known as Micronesia, is a sprinkling of islands over an area of ocean as large as that of the continental United States. They stretch from the Marshall Islands in the east and westward to Palau, close to the Philippines. They stretch from the Equator in the south to the Northern Marianas—north of Guam.

Historically, these islands were German colonies prior to World War I and then held by Japan, under a League of Nations mandate, until they surrendered or were captured by U.S. forces in World War II. They have been held by the United States as a strategic trust under the United Nations ever since. Except for the U.S. responsibility to the United Nations in this context, they have been administered as U.S. territories.

Micronesia, with its population of about 140,000 people on their hundreds of islands, is in the process of dividing into four political entities, each of which will have a continuing relationship with the United States after conclusion of the trusteeship now scheduled for 1982. Under the terms of the compact terminating the trusteeship, the United States will maintain fiscal responsibility for health and education for 15 years. This is effectively for the remainder of this century.

The strategic importance of the U.S. presence in these islands is self-evident. Furthermore, incursions of political influence of other powers would compromise the security of U.S. bases in Okinawa, Guam, and Hawaii. Therefore, it is in our own national self-interest to work with the Micronesians in establishing a society unsuited for political exploitation of the kind that bedevils our security in the Caribbean.

Health care delivery in Micronesia is carried out by 17 expatriate physicians, mostly Americans, Canadians, and Filipinos, and about 30 medical officers. These latter are graduates of an excellent but long-discontinued training program in Fiji. In addition, there are about 60 MEDEX— physicians' assistants—and about 150 nurses.

We have a few Micronesians in medical training at the University of Hawaii, and one has graduated and returned to Palau. The nurses are trained at a small school of nursing, now part of the 2-year Community College of Micronesia in Ponape. The MEDEX are former nurses trained by the Micronesian medical officers and University of Hawaii faculty.

This small and dedicated group of health professionals forms the whole system for the population of 140,000, and for good logistic reasons, they tend to be concentrated in or near the nine hospitals in the district centers. Consequently, health care for the scattered population of the remote islands is by village-level workers and occasional doctors' visits on Government ships.

Disease problems are severe and are, as noted, more those of underdeveloped nations rather than what we like to think of as the American norm. Tuberculosis, leprosy, and filariasis, for example, are endemic; hearing defects from untreated infections, diabetes and leukemia are found at high rates of incidence.

This subcommittee has been highly responsive to the needs for health manpower training in the Pacific Basin and has developed specific language directing the Department of Health and Human Services to facilitate appropriate programs. This interest has been very much appreciated, and programs now underway are developing new health professionals in the islands. We respectfully urge that these be maintained and comparable programs in rehabilitation medicine and public health be developed.

We suggest, further, that the subcommittee consider health manpower programs as part of a plan for establishing acceptable standards in these islands for the rest of the century. This is not only because it is fair and just to do so, but because stability in the islands is of strategic importance to our security.

Thank you, sir.

Senator INOUYE. Thank you.

Now, be a bit more specific. What do you mean by tuberculosis is endemic, and the other diseases?

Dr. ROGERS. As one of our pediatrics residents said, there are little children there with tuberculosis, that this is a disease we almost have to scratch to find patients to show to medical students today. But it's widespread in these Pacific islands.

Leprosy, which—we have perhaps 100 active cases in Hawaii. On Ponape, 10 percent of the population have leprosy.

Tuberculosis is running about 15 percent among children.

Senator INOUYE. The children population. What about the total population?

Dr. ROGERS. The total population—a grim fact of these epidemiological statistics is, where you have a high incidence of disease among the children, the death rate means that you do not have higher incidence among that of adults.

Senator INOUYE. What about diabetes and leukemia?

Dr. ROGERS. The Marshall Islands, one-half of the people of middle age have diabetes mellitus.

Senator INOUYE. One-half?

Dr. ROGERS. One-half; this is probably a genetic defect.

Senator INOUYE. What about leukemia?

Dr. ROGERS. Ponape, the incidence of child leukemia is one of the highest in the world.

Senator INOUYE. What would that be?

Dr. ROGERS. It is 10 times the expected rate.

Senator INOUYE. How would this compare with Haiti?

Dr. ROGERS. Better, in that the Micronesians are not malnourished, because of the food stamp and commodity program.

Senator INOUYE. What about the other, tuberculosis and leprosy?

Dr. ROGERS. Leprosy in Micronesia is certainly higher than in Haiti. The incidence of tuberculosis would probably be comparable.

Senator INOUYE. Do you have any cost figures that would be involved in your suggested program?

Dr. ROGERS. Yes, sir. They could—we think it would take $1 million to develop a plan for the rest of the century, and after that, about $20 million a year to operate a public health and preventive medicine program such as we have described.

Senator INOUYE. Your statistics are horrendous, and I assure you, the subcommittee will take this matter very seriously. We hope we can do something about it.

Thank you very much, sir.

[The statement follows:]

STATEMENT OF TERRENCE ROGERS

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Micronesians in establishing a society unsuited for political exploitation of the kind that bedevils our security in the Carribbean.

Health care delivery in Micronesia is carried out by 17 "expatriate" physicians, mostly Americans, Canadians and Filipinos, and about 30 "medical officers". These latter are graduates of an excellent but long-discontinued training program in Fiji. In addition, there are about 60 MEDEX (physicians' assistants) and about 150 nurses. We have a few Micronesians in medical training at the University of Hawaii and one has graduated and returned to Palau. The nurses are trained at a small school of nursing, now part of the two-year Community College of Micronesia in Ponape. The MEDEX are former nurses trained by the Micronesian medical officers and University of Hawaii faculty.

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This Sub-Committee has been highly responsive to the needs for health manpower training in the Pacific Basin and has developed specific language directing the Department of Health and Human Services to facilitate appropriate programs. This interest has been very much appreciated and programs now under way are developing new health professionals and providing continuing education and update to the existing professionals in the islands. We respectfully urge that these be maintained and comparable programs in Rehabilitation Medicine and

Public Health be developed. We suggest, further, that the Sub-Committee consider health manpower programs as part of a plan for establishing acceptable standards in these islands for the rest of the century. This is not only because it is fair and just to do so, but because stability in the islands is of strategic importance to our security.

STATEMENT OF DR. JEANNE SPURLOCK, DEPUTY MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION

Senator INOUYE. Next we will hear from a panel testifying about various aspects of alcohol, drug abuse, and mental health programs. First on the list is Dr. Jeanne Spurlock, deputy medical director of the American Psychiatric Association. Then we will hear from the rest of the panel, David Sandler, director of government affairs, National Council of Community Mental Health Centers, accompanied by James Cox, board member; Mrs. Jeff Van Sickle, executive committee member for the National Mental Health Association; Richard Pruss, president of the Therapeutic Communities of America; Diana Tabler Williams, director, Office of Public Policy, National Council on Alcoholism; and Margaret T. Gordon, director, Center for Urban Affairs and Policy Research.

Dr. SPURLOCK. Thank you, Mr. Chairman. My name is Jeanne Spurlock. I am a child psychiatrist and one of the three deputy medical directors of the American Psychiatric Association which is a medical specialty society representing some 26,000 psychiatrists nationwide. My testimony is presented on behalf of the American Psychiatric Association, and the American Academy of Child Psychiatry, and a number of other groups, nationwide, that are identified in my prepared statement which you have said is part of the hearing record.

I will summarize my prepared comments which have also been stimulated by our concern for perhaps as many as 30 million citizens of the country in need of mental health treatment, many of whom go unaided.

Also, on behalf of 2 million persons who have been and would be diagnosed as schizophrenic, who will receive no care—2 million who suffer from profound depressive disorders and more than 1 million with organic psychoses of toxic or neurological origins and other permanent disabling mental conditions who will remain without treatment.

I am also speaking out of concern for as many as 25 percent of those elderly who have been, or will be, written off as senile, whose conditions are actually misdiagnosed.

And worse still, I am speaking out of concern for perhaps more than 9 million children in this country who suffer from some emotional disorder and of whom fewer than 10 percent receive treatment.

Senator INOUYE. May I interrupt at that point?

Dr. SPURLOCK. Yes.

Senator INOUYE. You indicated that 9 million elderly are misdiagnosed as senile?

Dr. SPURLOCK. Yes; I think so often because of physical problems which very often result in some mental disorder, the physical disorder perhaps being more attended to because of certain authorities. The mental disorders are not attended to. So that very often, these elderly patients for one reason or another—very often because of misdiagnoses, get shunted into nursing home facilities without the capacity to treat the mental disorders.

Senator INOUYE. How can we correct that?

Dr. SPURLOCK. I think one way we can correct it is to hopefully reverse the decisions about phasing out clinical training.

This was one phase of my testimony that I wanted to highlight in the summation.

Senator INOUYE. Please proceed.

Dr. SPURLOCK. I have noted in my prepared text that we have indicated our awareness of concerns about the need to balance the budget and have also called attention to our appreciation for the need for all of us to do our fair share to achieve economic recovery.

But I have also noted the importance of addressing that which we believe to be shortsighted cuts in Federal spending, and have identified three segments to an overall theme that is the inadequacy of our President's budget.

First, I wish to address the inadequacy of the budget for research performed at the agency of Alcohol, Drug Abuse and Mental Health Administration, particularly in its equities with respect to the funding provided by research conducted under the auspices of the National Institutes of Health as compared to that.

While gratified by the restoration from the original mark slashing of research of fiscal year 1981 of a little over $113,246,000 and now $102 million plus, recommended for fiscal year 1982.

We are deeply distressed by the rescission of $10 million in fiscal year 1981, which is all directed toward behavioral and social science research. We see this action perhaps as another example of discrimination against the mentally ill.

The second area of concern that we have addressed as indicated in my prepared statement is the tragic decision to phase out Federal funding for NIMH clinical training programs.

Mr. Chairman, I would like to emphasize that one of the key programs in which you have had an important leadership role is now stated in with these funding decisions and cut back. I am referring to the minority fellowship program which has been conducted under the administration of five national mental health organizations. This decision, despite a clear shortfall in the recruitment and training of minorities, into the mental health professions, will, I believe, generate tremendous negative things for all of us, nationwide.

The third segment of the theme of my testimony is the egregious decision to reverse the establishment of a mental health systems act, an act which was passed by Congress.

This act, I believe, of abolishing the earmarking of funds for community programs for the mentally ill will, in the best of all worlds, make for inappropriate institutionalization. We already see some painful evidence of this as community programs have less funding, with many of the mentally ill being shunted into the correctional system rather than into mental health. Thank you.

Senator INOUYE. Thank you very much. Our next witness is David Sandler of the National Council of Community Health Centers.

STATEMENT OF DAVID SANDLER, DIRECTOR OF GOVERNMENT AFFAIRS, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH

Mr. SANDLER. Thank you, Mr. Chairman. I am director of government affairs for the National Council of Community Health Centers. With me is James Cox, director of the Tulsa Psychiatric Center in Tulsa, Okla. Our organization represents over 750 community providers of mental health.

Community mental health centers are nonprofit and free services for those unable to pay. In 1975 an estimated 2.4 million people, most of whom had incomes of less than $5,000, received services in community mental health centers. We strongly urge this subcommittee that the act that passed the Senate only a few months ago, it had bipartisan support, and former Senator Schweiker was one of its sponsors. We also urge the subcommittee to oppose the administration's fiscal year 1981 rescission request for mental health and alcohol and drug abuse.

Congress indeed has the responsibility to stop programs which do not work and to amend those which are not functioning properly.

Congress, however, will be abrogating its responsibility to the American people, especially those who have no choice but to depend on the Government for the basic necessities of life. If it dissolves all health programs and hands a lump sum over to the States with no strings attached. At a time when we are concerned about fraud, what could be more dangerous than to hand over $1.1 million with instructions to use for health services without any regard if the State has the manpower or the mechanism in place to see that these are disbursed properly.

The Mental Health Systems Act took 4 years to develop. It creates a partnership between all three levels of government: Federal, State and local, in the delivery of mental health services. If we are going to continue the trend toward deinstitutionalization and allow those afflicted with mental illness in their communities where they can remain with their families, it is essential the Mental Health Systems Act be adequately funded by Congress and the new partnership be urged to work. We agree and hope that Congress will take the necessary steps to make this possible. Thank you.

Senator INOUYE. Thank you very much. I would just like to make an observation at this point.

I am certain that all of us will agree that according to the mailbag, most of the people who write to Members of Congress are strongly in favor of cutting down on costs of the Government. Not going into specifics.

The second observation is that 2 years ago I sponsored an amendment to the section of the appropriation bill and suggested that two specialties, nurse specialties, be permitted to have reimbursement rights. One, nurse midwives, the other psychiatric nurses.

According to background, psychiatric nurses have a more—the requirements—university requirements are much more demanding than that of a nurse midwife. Yet, the committee could relate itself to the nurse midwife and adopted that immediately without any opposition. When it came to the psychiatric nurse, almost to a person, they opposed it. And what I am trying to tell you is that for some reason, the 20th century hasn't reached the Congress. [Laughter.]

When it comes to mental health, psychiatry, many members shy away. That being the case, I would suggest that it would take more than a panel to convince this Senate.

If you have people who can write, I suggest you do some writing. Thank you very much.

The next witness is Mrs. Jeff Van Sickle.

STATEMENT OF MRS. JEFF VAN SICKLE, EXECUTIVE COMMITTEE MEMBER, NATIONAL MENTAL HEALTH ASSOCIATION

Mrs. VAN SICKLE. Thank you. My name is Mrs. Jeff Van Sickle and I am speaking as a volunteer for the 1 million members and volunteers of the Mental Health Association. I think you have already said, sir, that our full text is entered into the record?

Senator INOUYE. Yes.

Mrs. VAN SICKLE. Medicaid cuts, combined with abandonment of the Mental Health Systems Act which is an absolutely appalling possibility, would in effect set the mental health movement back 15 to 20 years. A Federal role needs to be provided and preserved.

Special interests in the States will spend funds in response to regional politics, eclipsing any objective measurement of need. I have to give credit to the Baltimore Sun for that phrase.

Right now, mental illness is costing Americans $30 billion a year. And it is still the No. 1 cause of hospital admissions. Yet, less than 6 percent of the Federal health service's dollars is allocated to the problems of mental illness.

The repeal of the Mental Health Systems Act portends a return to institutionalization, less involvement of the private sector, and a loss of human productivity as well as the loss of a system designed to provide delivery of services to those who are truly in need. This also returns to the States' control in planning functions.

The Mental Health Systems Act is the result of 4 years of intensive work by citizens, providers and State representatives and insures a partnership approach focusing on those most in need.

We oppose repeal and earnestly ask you to start up funding in 1982. I was under the impression my time would be very limited and I would like to suggest to you and other committee members, sir, that you give special attention to pages 4, 5, and 6 of the text for a most clear and persuasive justification of the Mental Health Association's position on research.

I would like to add that it is heartbreaking to find ourselves facing such major and inequitable setbacks when we are on the brink of critical breakthroughs in effective mental health service systems and exciting research discoveries for which we have long been advocating. What seems heartbreaking for us, and we fear will become heartbreaking for those who designed this legislation and budget, with the expectation of reducing the cost to the American people, or is this all a rather shortsighted attempt to reduce the Federal budget and deficit with little concern for the long-term effect on the States and local governments? Somewhere the bill for the poor has to be paid. My sense is along with your remark, sir, that there is so much ignorance, and yes, even fear, about mental illness that there is a tendency to deal with it summarily. And I would like to say again that I urge that there be some reading done on the information on research in our text.

Senator INOUYE. I can assure you, I will read every page, and I will urge my colleagues to do likewise.

Next witness is Mr. Richard Pruss, the Therapeutic Communities of America.

STATEMENT OF RICHARD PRUSS, PRESIDENT, THERAPEUTIC COMMUNITIES OF AMERICA

Mr. PRUSS. Thank you. I am grateful for this opportunity to testify. I will be testifying on the appropriation for the National Institute of Drug Abuse.

I am Richard Pruss, president of Therapeutic Communities of America. We are a consortium representing more than 600 private not-for-profit drug treatment agencies. We are the direct providers of treatment and services, the frontline in the drug rehabilitation effort. I will limit my remarks to concern themselves with two categories of funding within the NIDA budget. They are State 409 funds and community programs or 410 funds.

The Republican platform on drug abuse stated that:

> Private, nonprofit drug abuse rehabilitation agencies have taken the lead in fighting drug abuse, and they deserve greater cooperation and flexibility from Federal, State, and local agencies and grant programs.

The rescission proposed in the fiscal year 1981 budget, in 409 and 410 funds, reduces funding for those programs by $31 million and represents both a 16-percent cut in funding and elimination of 409 funds entirely.

Now after being proposed for total elimination in the former administration's fiscal year 1981 budget revisions submitted last March, the House Committee on Appropriations restored the formula 409 programs to the NIDA budget. The Committee report said: "This would have done irreparable damage to a program of absolutely essential services. It is clear that many persons would lose services in such an abrupt transition."

The reason for restoration remains the same today. Treatment programs throughout the country are at or above 100 percent of capacity. Many have long waiting lists. According to DEA, 20 times the amount of opium is being grown and exported at this time than there was in the late 1960's and early 1970's, when the United States experienced a severe heroin epidemic and 700,000 American citizens became addicts.

The primary countries of origin are Iran, Afghanistan, and Pakistan. With no cooperation coming to slow the traffic at its source, DEA's efforts are greatly curtailed. Some very recent statistics from my home State, New York, indicate that heroin that we speak of is on the street. From January through September 1980, the episodes of heroin emergency room related happenings increased 141 percent since 1979. Drug-dependent mortality in New York City deaths attributed to narcotic drugs increased by 92 percent during the same period. The purity of street heroin has gone from 3 to 5 percent to 6 to 7 percent. The average cost of heroin on the streets of New York has decreased by 10 to 15 percent in the last year.

Prison detoxification admissions rose 30 percent in the first 9 months of 1980. Treatment admissions with heroin as primary drug of abuse between 1978 and 1979, heroin admissions increased 26 percent. Most of the people who are heroin addicts, 40 percent, are military age between the age of 18 and 24.

Polydrug abusers are serviced by the private not-for-profit providers; 23 percent of all of the residents in therapeutic communities are polydrug abusers and are under the age of 19.

It should be noted while some of the States add little money to the drug abuse efforts, New York, California, Pennsylvania, Texas, and Illinois appropriate $196 million of State revenue for drug abuse. An amount approximately equal to the Federal Government's contribution. There is no reason to believe that if the Federal commitment shrinks, the State legislatures will be willing to expend State revenue to the extent that they do currently. To rescind $31 million at this time will bankrupt and, therefore, close many of the private service providers, as well as State programs.

We are halfway through a fiscal year. Obligations have been established. The Federal Government must keep its word to the State, to the private providers of services and to the American people. Although not yet authorized in fiscal year 1982, the administration has proposed placing 409 and 410 funding in the health services block grant and reducing that grant by 25 percent.

The administration cites increases in appropriations in recent years within the area of health. Drug abuse funds have not increased. Combined formula 409, 410 appropriations have been cut from $200 million in fiscal year 1979 to $191 million in fiscal year 1981 without a proposed rescission, which would reduce the funds by a total of $40 million or 20 percent. These reductions would come prior to the field facing the consolidated block grants and an additional 25-percent cut.

In a press conference on March 6, President Reagan made the following statement regarding drug abuse:

> I think this is one of the gravest problems facing us internally in the United States. It is my belief that the answer to the drug problem comes through winning over the users to the point that we take the customers away from the drugs. And I envision, whatever we can do at the national level, to try to launch a campaign nationwide. Because I think we are running the risk of losing a great part of a whole generation, if we don't.

And yet, the proposed rescission, the reduction through block-grant funding would reduce appropriations from fiscal 1979 through fiscal 1982 by 45 percent. I repeat that the programs are currently operating at or above 100 percent of capacity and heroin in greater quantity than we have seen, is being produced and smuggled into the United States.

I would like to cite one example of the shortsightedness of those budget cuts. Using therapeutic communities as an example, a survey of a group of therapeutic communities indicated that one out of three clients is mandated into a treatment program as an alternative to prison. Therapeutic communities are funded at a total of $6,000 per slot, per year. That is residential 24-hour-a-day treatment. Of that amount the Federal Government contributes only $3,600, with the balance being provided by other than Federal funding. Imprisonment costs $20,000 per year on the average.

We would have to bring people currently in our care—we are not talking about treatment slots and cushion funds. We are talking about throwing people out of a treatment system at or above capacity back to the courts, have them mandated to prison. The cost to the Government via treatment to $6,000 a year, prisons $20,000 a year. The information cited doesn't take into account the cost of crime, the loss of productivity in the marketplace, or the fact that treatment breaks individuals out of a welfare dependency cycle, creating taxpaying, productive members of society. One of our member agencies, based on this study, revealed that the annual personal income taxes paid by its graduates now exceeds the annual grants received by that program in funding.

The proposed placement of drug abuse into a block grant with 14 health providers will have a devastating impact on the national war on drugs, which must continue. State militias are not called upon by Washington to provide our national defense. Neither can they do more than participate in a partnership with the Federal Government in our war on drugs. There is a continuing need for partnership with the officials in Washington and the Nation's providers of nonprofit treatment. We cannot hope to maintain that partnership without the help of Congress.

In September of last year, at the National Alcohol and Drug Coalition in Washington, Senator Orrin Hatch addressed the group and made the following remarks:

> Government must support social service programs which are geared to foster independence. Government must not accept drug abuse but rather reaffirm our faith in the strength and potential of our youth to lead free and productive lives, drug-free.
>
> It is time that Washington exerts moral leadership and sounds the bugle in the war for a drug-free society.

We could not agree more with that statement. We have the experience and skill and motiviation to help. With the commitment of this committee, we can succeed.

Senator INOUYE. How many persons were serviced by your agencies?

Mr. PRUSS. Approximately 13,000.

Senator INOUYE. Your contention is that if this budget rescission goes through, those 13,000 have to go to prison?

Mr. PRUSS. No; approximately one-third of the people in our programs, are mandated by the courts. Therefore, if the decision goes through, in addition to the 409 moneys, there are 410 funds. So I could not tell you that that third of the population would have to go back to prison. It would be a percentage of the overall funding, whatever percentage was cut, approximately that amount of residents in our care would have to be brought back to the courts for sentencing.

Senator INOUYE. Thank you very much, sir.

Our next witness is Diana Tabler Williams, representing the National Council on Alcoholism.

STATEMENT OF DIANA TABLER WILLIAMS, DIRECTOR, OFFICE OF PUBLIC POLICY, NATIONAL COUNCIL ON ALCOHOLISM, INC.

Ms. WILLIAMS. Thank you, Mr. Chairman. Thank you for the opportunity to testify on appropriations for Federal alcoholism programs on behalf of the National Council on Alcoholism.

NCA is a private voluntary organization comprised of some 230 local councils on alcoholism throughout the country and a national board of directors, all of whom volunteer their [illegible] the national efforts and the community efforts, to combating [illegible] of alcohol, providing education about its impact on the community.

I want to address two issues before the subcommittee, first is the request for rescission of funds already appropriated for fiscal 1981, and the second is the President's request for 1982 for the National Institute on Alcohol Abuse and Alcoholism.

The President has requested the rescission over $53 million from the Institute's programs in 1981. The National Council on Alcoholism strongly urges this subcommittee to act on that decision. As you well know, those funds have been appropriated twice by the Congress, for use in 1981. And the programs which rely on those funds have really been 6 months on borrowed time. Efforts are under way within the States to replace these funds which have not been included in the request for 1982, but NCA feels strongly that the commitment is there for this year, and we strongly urge that the commitment be kept.

I would also like to point out that many State legislatures have already adjourned. Some are close to adjournment. Others by the time this committee completes its action on the 1981 budget will be at a point beyond being able to revise their budgets for this fiscal year.

We are looking at a situation of literally closing the doors on publicly supported programs. We strongly hope that the committee will not rescind these funds for 1981.

Concerning the budget for alcoholism in fiscal year 1982, the President's request represents an approximately 77-percent reduction in the program capability of the National Institute on Alcohol Abuse and Alcoholism. We argue that this is a devastating reduction.

We are asking an institute which administers research and service programs to combat the third leading cause of death and illness in this country to take what is in our view a disproportionate share of budget cuts.

Senator INOUYE. Alcohol is the third leading cause of death?

Ms. WILLIAMS. Yes, sir.

The National Council on Alcoholism is proposing an alternative to this request which would maintain some support to States to assist them in carrying out their alcoholism service programs and an increased priority for research and knowledge development at the national level. I ask that in conjunction with this request, a recent report of the National Academy of Sciences Institute of Medicine on the need for alcoholism research be included as part of the record.

[The document follows:]

ALCOHOLISM, ALCOHOL ABUSE, AND RELATED PROBLEMS: OPPORTUNITIES FOR RESEARCH

PART I: OVERVIEW

Introduction

In this country, as in many others, alcohol* is a substance of major abuse, which leads to a wide range of physically, emotionally, and economically costly public health problems. Some 100 million adult Americans drink apparently without experiencing serious adverse consequences of alcohol abuse. Alcohol has a socially accepted role in rituals of work, family, play, and worship. However, there also are an estimated 13 million American problem drinkers 1/. Their physical and mental health will decline, often disastrously, because of abuse of alcohol. Millions of other Americans experience disruption in their lives as victims of intoxicated drivers or because of the alcoholism of family members.

The unanswered questions about alcohol abuse and alcoholism are numerous. For instance, why is it that of those who enter into any treatment program, some have long-term improvement, some have short-term improvement and will relapse within a year, and some show no improvement at the end of the program? We do not understand why some may benefit from a given treatment strategy while others do not; we do not understand why some alcoholics seek treatment while many more do not; and, we do not understand why some alcoholics experience remission without undergoing treatment.

Research is needed on the causes and effects of alcoholism, and on other problems related to the abuse of alcohol, to enable the design of effective prevention and treatment programs. Much is known about the biochemistry of alcohol, its metabolic disposition and pharmacokinetics, and some information is available about its pharmacologic actions, but a full understanding of its effects on the human body and its role in our complex social system has yet to be attained by biomedical and social scientists. Research in this area should lead to a reduction of the human suffering and the multi-billion dollar toll that alcohol abuse and alcoholism exact from society.

This report represents an attempt to assess the greatest opportunities for productive research in the immediate future. To place these opportunities into a relevant context, the burden of illness, the economic cost to society, and the size, scope, and structure of the current research effort related to alcohol abuse and alcoholism also are presented.

The Study Plan

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) asked the Institute of Medicine to:

> Review the research field and assess the scientific opportunities of particular research areas as viewed over the next five years. In particular, an assessment should be made of the findings of past research

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*In this report, "alcohol" means ethanol or an alcoholic beverage. "Drinking" means consumption of alcoholic beverages. The terms "alcohol abuse" and "problem drinking" signify drinking patterns in which consumption may be well above average, although not always on a regular basis, and in which some problems linked to drinking (e.g. arrest for drunken driving or a decline in job performance) have occurred. This committee does not attempt a single definition or set of diagnostic criteria for "alcoholism," but notes that those generally in use include quantities consumed and recurrence of the physical signs (e.g. blackouts), habits (e.g. morning drinking), and/or life disruption (e.g. job absenteeism) commonly associated with continuing, compulsive, excessive use of alcohol.

> and the current state of knowledge, the feasibility of undertaking research in the area at this time, the availability of necessary techniques and technology, and the interest and availability of necessary research manpower. Research areas to be reviewed would include issues related to the medical and psychological etiologies and consequences of alcohol abuse and alcoholism, the pathogenicity of alcohol, the relation of alcohol use and abuse to other major medical disorders, the development of diagnostic procedures and techniques, and the applicability of research methodologies (e.g., clinical trials) to the development and assessment of specific treatment and prevention techniques. The contractor shall synthesize the information developed to produce recommendations for NIAAA regarding research program directions for the coming five years, in terms of those scientific areas which seem to present the greatest opportunities for productive and useful research.

Furthermore, Dr. Gerald Klerman, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) encouraged the study committee to consider administrative arrangements and their impact on scientific opportunity.

An eight-member committee* was established to conduct the study. Six of the members also chaired panels established to prepare detailed reports on a discipline-oriented cluster of research topics. The panels were:

Panel 1	Biochemical and Genetic Issues
Panel 2	Neuropharmacological Issues
Panel 3	Clinical and Epidemiologic (Including Genetic) Issues
Panel 4	Psychosocial Issues
Panel 5	Prevention Issues
Panel 6	Treatment Issues

A total of 27 scientists in addition to the six members of the study committee were responsible for the panel reports. The study committee also held an open meeting and received written statements from 21 other scientists expressing their views of scientific opportunities in the field. The draft panel reports were submitted to a number of scientists with selected specialties for informal review of the assessment of opportunities in their particular area of expertise.

The panel reports are presented in a disciplinary framework. However, the committee members and many of the panel members agree that an interdisciplinary approach will afford the greatest likelihood of solving many of the puzzles of alcoholism and alcohol abuse. Therefore, the scientific opportunities enumerated in each panel report are integrated in this overview.

Two additional aspects of research in alcohol-related problems were examined. The burden of illness, including the economic burden of alcohol-related problems, was examined to enable more informed decisions on allocation of resources. This information is presented in detail in a background paper on economic costs. The committee also looked into the current research effort in alcohol-related problems. We sought to develop some sense of the total dollar investment in alcohol research, where it comes from, and how many investigators are supported in this area. The panel reports, the economic costs paper, and the review of current research support constitute Part II of this report.

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*Among the eight committee members, a total of three have a relationship to NIAAA: two are members of the NIAAA National Advisory Council (one of whom was appointed to the Council subsequent to his appointment to the study committee); one of these and an additional member received research grant support from NIAAA (at Alcohol Research Centers). None serves on an NIAAA research review committee, and none receives research funds from the beverage industry.

Magnitude of the Problem

The Burden of Illness

According to the NIAAA, there may be as many as 10 million adult Americans (7 percent of the adult population) and another 3.3 million youths who are problem drinkers 1/. Estimates of the annual number of deaths related to alcohol abuse range from 50,000 to 200,000 annually 1/. Cirrhosis of the liver was the fourth leading cause of death in 1976 for the age group 25-64 years, exceeded only by heart disease, cancer, and stroke 2/. Many deaths can be directly attributed to alcohol, as in the case of many of the 31,500 annual deaths from liver cirrhosis, but the relationship of mortality and alcohol also may be indirect, as in the case of motor vehicle accidents, falls, fires, suicides, and homicides. Furthermore, alcohol is a risk factor for other leading causes of death, such as cancer 3/.

Health complications related to alcohol abuse include liver cirrhosis, some cancers, gastritis, hepatitis, pancreatitis, cardiomyopathy, arrhythmias and sudden cardiac death, alcoholic psychosis and other psychiatric disorders, and malnutrition with its sequelae 1,4/. Alcohol abuse is a prominent risk factor (along with smoking and obesity) in a disproportionately high-cost group of hospitalized patients 5/. Evidence is accumulating to implicate excessive drinking by pregnant women in the etiology of a set of birth defects that include both physical malformation and mental retardation 6,7/.

It has been estimated that as many as half of all highway fatalities and 10 to 30 percent of injuries from auto accidents may be alcohol related 1,8/. In addition, alcohol is suspected of playing a critical role in many industrial accidents, drownings, fire fatalities, falls, and suicides 9/. Furthermore, alcohol use often occurs in association with violence directed at others, such as child and spouse abuse 10/.

This cataloguing of adverse health effects is impressive yet incomplete, especially in that it ignores the psychic costs that arise from such problems as broken homes, disrupted childhoods, sexual dysfunction, and criminal activities that result, at least in part, from alcohol. It also is incomplete in that it ignores recent reports suggesting that consumption of alcohol may be associated with a lower incidence of coronary heart disease 11,12/. However, there is no scientific consensus on this issue. Furthermore, just as psychic penalties of excessive drinking are tallied, so too should the possible psychic benefits of moderate drinking be taken into account. A reckoning of the effect of alcohol on health, and an assessment of related research opportunities, would be incomplete were it to gloss over benefits, yet the negative consequences overwhelm the positive. Regardless of any putative beneficial effects, the detrimental effects are enormous and were the focus of the committee's attention.

Economic Costs

There is no standard social unit of account by which to aggregate the diverse physical, mental, and social consequences of abuse of alcohol. However, many of these problems do have economic consequences and the aggregation of these costs provides at least a partial measure of the impact on society.

The concept of economic cost includes opportunity cost, or, in this case, what is foregone by society as a result of alcoholism and alcohol abuse. The economic costs of alcoholism and alcohol abuse thus are made up of (1) the loss to society of potential production resulting from morbidity and mortality associated with alcohol, and (2) the value of the resources expended to cope with the consequences of alcohol abuse that could have been used instead for the production of other goods and services. It should be emphasized that this is only a measure of economic costs, not of full social costs. There are six major areas in which significant economic costs are attributed to alcohol abuse—lost production, health care costs, motor vehicle accidents, fire losses, economic cost of crime, and social responses to alcohol abuse.

A major study of the economic costs of alcohol and alcohol abuse was conducted by Policy Analysis, Inc. 13/ for the NIAAA. The estimate of the cost of alcoholism and alcohol abuse for 1975 was $42.9 billion, up from the $25.8 billion estimated in 1971. The estimates of the several components of economic cost for 1975 are as follows:

lost production	$19.6 billion
health care costs	12.8
motor vehicle accidents	5.1
fire losses	.6
crime	2.1
social responses	2.7
	$42.9 billion

An estimate may be thought to be too high and too low, and this estimate has been controversial since its promulgation.* Among the questions that it raises are: how should responsibility be quantitatively apportioned among various factors known or suspected to be significant in the etiology of complex phenomena? how should costs be estimated when some relevant data are not available? The committee therefore commissioned a detailed study of the economic costs of alcoholism. This analysis (Economic Costs in Part II) led the committee to believe that because of exclusions from each of the cost categories and some conservative choices among alternative measures of the same costs, the $42.9 billion total cost estimate for 1975 may be a substantial understatement of the total societal costs of alcoholism and alcohol abuse. Those costs could range as high as $60 billion, even when taking into account any upward bias in the estimate for 1975.

Allocation of Research Resources

The burden of illness and economic costs described above indicate a great need for research programs to find causes of and measures against alcoholism, alcohol abuse, and their adverse consequences. Research of any type consumes scarce resources that have alternative uses. Allocation of research dollars involves explicit or implicit choices regarding priorities, costs, and potential benefits of various research alternatives. Allocation of resources should be viewed in two separate contexts: 1) research on alcoholism and alcohol abuse as compared with research on other problems; and, 2) comparisons of research efforts within the alcoholism/alcohol abuse field.

Factors to be considered in setting relative priority include the magnitude of each health problem (the economic costs, prevalence, and mortality), the scientific opportunities (as a function of such matters as the available knowledge base, human resources, technology, and methodology), the probability of success in attaining new knowledge from the research efforts, the estimated tangible benefits including reduced morbidity and mortality, individual investigator curiosity, and the public's perception of the importance of the health problems 14/.

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*The value of lost production is a case in point. Possible sources of underestimation are detailed in Part II of this report in "Costs of Alcoholism and Alcohol Abuse and their Relation to Alcohol Research." There also are sources of overestimation--for example, the value of lost production is partly derived from lost income (the relative decrease in income among problem drinkers compared to the general population), but this may not be a realistic gauge of production in a period of high unemployment. The committee recognizes that some economists would prefer to deal separately with estimates of direct costs and indirect costs and would place primary emphasis on direct costs.

It is beyond the scope of this report to make a detailed analysis of all the factors that should be considered when establishing an alcohol research budget, with its implicit judgment on priority relative to other disorders. However, the committee feels it is sensible, once having established the magnitude of the problem, to look at our research investment in this area and compare it to our research investment in other health areas.

Just as it is difficult to establish with absolute certainty the economic costs of a given disorder, it is also difficult to calculate research expenditures for it. Relevant research may be supported by a variety of agencies that may or may not have a specific disease mission. Research may be "relevant" to a number of disorders. Furthermore, research costs may be hidden in other funding categories (e.g. investigator salaries, training, treatment) and indirect costs may be included or excluded in various agencies' research budget calculations.

Although these and other factors make it difficult to determine precise dollar levels of research, even a cursory examination of the available figures indicates that alcohol research is not funded at a level commensurate with the economic costs it imposes on society or at a level comparable to research funding for other major health disorders. (See Table 1.)

TABLE 1. Health Research Dollars in Relation to Economic Cost.

Disorder	NIH/ADAMHA Lead Institute Research Effort	Economic Cost	Research Dollars Per Thousand Dollars of Cost
	1978 $ in millions	1975 $ in billions	$
Alcoholism/Abuse	[a] 16	[c] 43	0.4
Cancer	[b] 627	[d] 19	30
Heart & Vascular Disease	[b] 284	[d] 46	6
Respiratory Disease	[b] 69	[d] 19	4

Sources:

[a] *ADAMHA Data Book, 1979* 16/

[b] *Basic Data Relating to the NIH, 1979* 17/

[c] Berry *et al.* 13/

[d] *Health US, 1978* (Paringer *et al.*, May 1977 report) 15/

The economic costs in Table 1 include direct health care costs (money spent on prevention, diagnosis, and treatment) and indirect costs (lost production due to morbidity and mortality). In the case of alcoholism/abuse, estimated costs due to "alcohol associated" crime, fire, and motor vehicle accidents also are included 13/. The lost production cost for alcoholism and abuse does not include the value of unperformed household services, although this cost is included in the estimates for other disorders 15/. The costs derived from alcohol abuse as a contributing factor to some forms of cancer and heart disease and as a risk factor for high-cost hospitalization are not included.

The figures for research expenditures are the research budgets for the disorders' respective NIH/ADAMHA Institutes 16,17/. These are underestimates of the total research effort; in each case other federal agencies and institutes may support relevant research. There is usually also some research support from states, foundations, and private sources. In 1978, about 60 percent of all health research and development in the United States was supported by the federal government, about 30 percent was supported by industry, and the remaining 10 percent was supported by states and private non-profit sources 17/.

More comprehensive, but still incomplete, figures on support of alcohol-related research have been obtained by the committee (see Federal Support of Research in Part II). In fiscal year 1979, the total federal support of alcohol-related research was about $55 million, although the total was only about $34 million for that portion of the research in which alcohol-related problems were of primary emphasis. The $22 million from NIAAA in fiscal year 1979, up $6 million from fiscal year 1978, accounted for about two-thirds of the federal research effort in which alcohol-related problems were of primary emphasis.

The alcoholic beverage industry until recently was not a vigorous supporter of research relative to the abuse of its products. The committee has been able to identify less than $300,000 per year of industry support (see Federal Support of Research in Part II). However, in June 1980 Harvard Medical School announced receipt of a $5.8 million gift from Seagram and Sons, for support over several years of biochemical and genetic research on alcohol metabolism and alcoholism.

There also is research on cancer, heart and vascular disease, and respiratory disease supported outside their respective NIH institutes. However, given the very large budgets for cancer and heart disease research, it is perhaps unlikely that the primary research effort was fifty percent above the indicated single institute level, as was the case for alcohol-related research in 1979. In considering the research/cost ratio for alcoholism and alcohol abuse, the bias in terms of research support probably is somewhat offset by the bias in the economic cost estimates. That is, for alcoholism/abuse, the research expenditures are underestimated, but the economic cost also may be underestimated.

From the data in Table 1, it can be seen that heart/vascular disease and alcoholism/abuse had about the same economic cost to society in 1975, but the heart/vascular disease research effort in 1978 was more than 17 times greater than that for alcohol-related problems. Both cancer and respiratory disease cost about half as much as alcoholism/abuse, yet cancer research is far better funded than research on all the other disorders taken together, and respiratory disease research receives about four times the alcoholism/abuse support level. Support of alcohol-related research is disproportionately low relative to the estimated economic impact--about one-tenth of the amounts spent on heart disease or respiratory disease, and 1/100 the amount spent on cancer research, relative to the economic impact of these disorders. Even if the estimate of research support for alcohol is in error by a factor of two or the cost figure is overstated, the imbalance in the support of research in alcohol-related areas relative to other health areas would still obtain.

Research Relative to Mortality

Mortality figures for cancer, heart and vascular disease, and respiratory disease are reported annually (see Table 2) 17/. Alcohol-related deaths are less easily counted, however, because alcoholism can contribute to fatal disorders that have other etiologies. Those deaths are seldom ascribed to alcoholism, because of physician reluctance to label alcoholics as such, and because alcohol is only one of several factors in many deaths due to traffic accidents, homicide, and suicide. Studies of the number of deaths attributable to alcohol vary widely in their results, in part because of their different methodologies and assumptions. For example, the estimates of the proportion of cases of cirrhosis of the liver linked to alcoholism range up to 95 percent and average about 50 percent 18/. In the studies discussed in NIAAA's 1978 report to Congress (Alcohol and Health III), most of the estimates of all alcohol-related deaths each year ranged from 50,000 to 200,000 1/.

When mortality data are used as the basis for comparisons of research efforts (Table 2), the support of alcohol-related research falls within the range of support for research on other disorders, although it is at the low end of the range.

TABLE 2. Health Research Dollars in Relation to Mortality.

Disorder	Mortality	Research Dollars Per Death[a]
	1976 deaths thousands	$
Alcoholism/Abuse	50-200[b]	80-320
Cancer (ICDA code 140-209)	377[c]	1663
Heart and Vascular Disease (ICDA code 390-458)	991[c]	286
Respiratory Disease (ICDA code 460-519)	121[c]	570

Sources:

[a] See Table 1 for 1978 Research Effort

[b] Alcohol and Health III 1/

[c] Basic Data Relating to the NIH, 1979 17/

Research Relative to Morbidity

With a long-term chronic condition such as alcoholism, prevalence figures—how many people are suffering from a disorder—may be preferable to mortality as a measure of magnitude and impact. An examination of the prevalence of the four groups of disorders, in relation to the level of research support for each, once again indicates that alcoholism and alcohol abuse research is disproportionately underfunded (Table 3).

TABLE 3. Health Research Dollars in Relation to Prevalence.

Disorder	Prevalence*	Research Dollars Per Case[a]
	1978 millions of cases	$
Alcoholism/Alcohol Abuse	13[b]	1
Cancer	3[c]	209
Heart and Vascular Disease	36[d]	8
Respiratory Disease (Chronic)	54[d]	1

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*The prevalence figures from the National Center for Health Statistics represent cases rather than people. Correction for people with multiple disorders reduced the 1972 heart disease prevalence figure by about 20 percent. People with unrecognized disease, who are not counted as cases, may offset errors due to double counting. The prevalence figure from the American Cancer Society represents people with a history of cancer--not all of whom have "active" disease.

Sources:

[a] See Table 1 for 1978 Research Effort

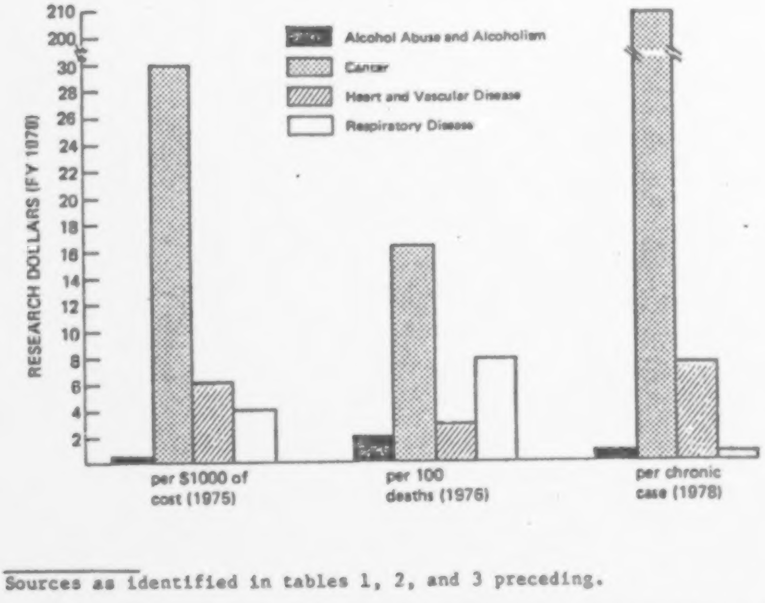
[b] Alcohol and Health III 1/

[c] American Cancer Society, Facts and Figures 1980 19/

[d] Provisional unpublished data from the National Center for Health Statistics. Heart and vascular disease cases (in millions) include heart disease (13.5), hypertensive disease (18.9), cerebrovascular disease (1.7), arteriosclerosis (0.7), and congenital anomalies of the circulatory system (1.3); respiratory disease cases (in millions) include chronic bronchitis (7.1), emphysema (2.1), asthma (6.0), sinusitis (22.5), hay fever (15.5), and other chronic conditions (1.0).

Upon consideration of three measures of the magnitude of the problem, this committee concluded that research support for alcohol-related problems is grossly underfunded (see Figure 1).

FIGURE 1. NIH/ADAMHA Research Investment in Selected Major Disorders Relative to their Economic Cost, Mortality, and Morbidity.



Sources as identified in tables 1, 2, and 3 preceding.

The committee wishes to make it clear that it has no criticism of the research expenditures in non-alcohol areas; Congress was wise in recognizing the large burden of illness of cancer and heart disease and supporting research in these areas. The committee does not want to disturb that, but it is time also to call attention to the burden of illness associated with alcohol. Ideally, additional funds for alcohol-related research would be authorized by Congress. However, this is unlikely during a period of budgetary restrictions. The committee believes that the proposed increased research expenditure could be financed at least in part by a reallocation of resources within NIAAA: a substantially greater fraction of the NIAAA budget should be devoted to research (see page 26). Industry also is a potential major source of support, as demonstrated by the recent impressive gift to Harvard University from Seagram and Sons, Inc.

Scientific Opportunities

Do the opportunities, research strategies, and scientists active in the field warrant an increased investment in alcohol-related research? Some think that infusion of money into a research area will in and of itself create "scientific opportunities," because the availability of research support will inevitably attract new investigators who will contribute new ideas and techniques. Others think that increased research support is only justified if scientific opportunities currently are not taken advantage of because of insufficient research funding. This difference of opinion does not apply to alcohol-related research because, in the judgment of this committee, numerous scientific opportunities are recognized and await investigation.

The major effort of this study was identification of these research opportunities. The charge to each panel was to indicate a limited number of research opportunities--those that showed the greatest promise of near-term success--rather than to provide an exhaustive listing of opportunities. We will now turn to the areas examined by the six panels and highlight what the committee felt were particularly compelling research recommendations.

Panel 1: Biochemical and Genetic Issues

The effects of alcohol and alcoholism engage nearly every aspect of biomedical research. Repeated exposure to alcohol can result in cellular damage as well as the development of alcohol dependency. These biochemical alterations may lead to decline in the mental and physical well-being of the individual. Much remains to be learned of the metabolic pathway(s) for alcohol, and the biochemistry of organ damage.

At least three enzymes provide possible pathways for the oxidation of ethanol: the soluble alcohol dehydrogenase (ADH), the microsomal enzyme oxidizing system (MEOS), and catalase, which may use ethanol as a donor in the reaction with hydrogen peroxide. In each case, the immediate products of ethanol oxidation are acetaldehyde and reduced intermediates. Much remains to be learned of the subsequent cascade of reactions and effects initiated by these products.

Although most studies of ethanol metabolism and enzyme biochemistry have been carried out using rat liver, limited studies with other animals (pigs, primates) have been performed. Human studies are difficult because current methods of liver cell culture are inadequate. Human liver tissue must be obtained by biopsy or autopsy. Despite these difficulties, human ADH has been isolated and purified in sufficient quantities to permit detailed physical and chemical measurements. Important interspecies and intraspecies differences in ADH have emerged, but researchers are not yet able to relate these differences to altered susceptibility to alcohol abuse and its sequelae.

The principal research opportunity reported by the Panel on Biochemical and Genetic Issues is the elucidation of the metabolic pathway(s) of alcohol. Research is needed to determine the physiologic significance of the several enzymes and enzyme systems—ADH (and its isozymes), catalase, and MEOS. Exploration of any of these raises additional questions, such as the degree and manner in which genetic factors influence these pathways, whether the oxidation of ethanol by the enzymes also influences the metabolism of other drugs or steroid hormones, and whether pathway or enzyme differences explain differences in ethanol tolerance. The consequences of ethanol metabolism—disruptions of the reduction-oxidation balance of the cell and the production of acetaldehyde and its metabolites—also need study.

Another major research opportunity is the development of more appropriate animal models to assess metabolism, intoxication, tolerance, dependency, and toxicity. The closer the correspondence with human systems and reactions, the greater the likelihood that research on animal models will shed light on these processes in humans. At the microscopic end of suitable experimental subjects are cell culture systems that will respond to ethanol. Studies directed to development of techniques to culture target organ cells, especially liver cells, or to induce relevant enzymes in fibroblasts would be timely.

Panel 2: Neuropharmacological Issues

Neuropharmacology, the study of the action of drugs on the nervous system, is of importance because the nervous system is the primary site at which alcohol produces intoxication, dependence, and neurotoxicity. Although there have been major advances recently in the fundamental understanding of the nervous system and its relevance to human substance abuse, relatively little of this knowledge has yet affected alcohol research. Here is an area ripe for research into the ways in which alcohol brings about its desired and undesired effects.

It should now be possible to explain the cellular and molecular causes of intoxication, and this explanation could lead to the development of methods to prevent or reverse intoxication. It should be possible to understand how the normal brain responds to repeated exposure to alcohol, to clarify sources of individual variation in response to the addictive and toxic actions of alcohol, and to develop antagonists to alcohol's shortand long-term effects on the brain.

Study of the effects of alcohol on physical properties of the cell membrane was deemed a major area of scientific opportunity by the Panel on Neuropharmacology. All agents influencing the biology of brain cells must interact with cell membranes in some fashion, and many aspects of alcohol's action can be examined with the tools of modern physical chemistry. With well defined membrane preparations, studies of membrane fluidity, lipid and enzyme composition, and transmembrane ion distribution appear to be fruitful areas for investigation. These studies should examine response to ethanol, the effects of diet (including alcohol) on this response, and the feasibility of using membrane properties as markers for susceptibility to alcohol problems (or toxicity differences).

Neurons communicate by secreting chemical messengers--transmitters--that influence responsive cells by attaching to specific receptor molecules. Another area rich in scientific opportunity is that of neurotransmitters and their receptors. Research would be timely on the effects of acute or long-term alcohol administration on the concentration, turnover, localization, and action of all known transmitters, and on the adaptive changes in neurotransmitter receptors that may ensue. This should include studies to test the possibility that some of the effects of alcohol can be mediated through the newly discovered brain neurotransmitters such as the endorphins, which are peptides with opiate-like activity. In addition, bioactive molecules that serve as transmitters or act upon the receptors for other transmitters so as to short circuit normal chemical communication, may be formed from alcohol. The great biological activity of such compounds when synthesized in the test tube, as well as the ability of opiate antagonists to reverse some alcohol actions, makes this general area worthy of additional investigation. Such research has a potential for the development of amethystic agents--drugs capable of counteracting the inebriating effects of alcohol.

Among the other research opportunities noted by the neuropharmacology panel are the need for studies of both acute and chronic effects of ethanol on all neuroendocrine systems, studies of cross-reactions with other drugs, studies of the effects of ethanol on fetal brain development, which require animal models, and studies of neuropharmacological/behavioral links in ethanol use.

Panel 3: Clinical and Epidemiologic (Including Genetic) Issues

Clinical and epidemiologic research can inform and improve clinical practice, as well as lead to major new ideas about the etiology, pathogenesis, treatment, and prevention of alcohol problems. Epidemiologic studies should explore differences in alcohol use, abuse, and consequent problems among different groups (ethnic, racial, gender, vocational, etc.), and not simply determine the prevalence of alcoholism among these various groups at any single time. The potential for understanding etiology derives from the ability to follow changes in individual behavior over time. Longitudinal studies of cohorts are expensive, but provide valuable information.

There is little uniformity as to what constitutes the dependent variable in many epidemiologic studies relating to alcohol abuse. There are relatively few studies using carefully defined discrete disorders, as seen in clinical practice, as the dependent variable. This leads to a gap between clinical and epidemiologic studies. If epidemiologic data are to be meaningful for clinical care and for prevention, some concept of a definable clinical disorder must be retained.

Four types of risk factor research apply to the alcohol field: 1) risk factors for intoxication, other forms of alcohol abuse, and alcoholism, 2) risk factors for the various clinical consequences of excessive consumption of alcohol, 3) alcohol abuse as a risk factor in disorders not directly linked to alcohol, and 4) alcohol abuse as a risk factor for (other) psychiatric disorders.

Research into the epidemiology of ethanol use and its consequences affords a significant opportunity for scientific study, according to the findings of the Panel on Clinical and Epidemiologic Issues. For example, epidemiologic studies are needed to identify any links between alcoholism and other psychologic and behavioral disorders, such as depression, antisocial personality, or abuse of other substances; to help determine gender and genetic differences in susceptibility to alcohol-induced liver disease and other sequelae of alcohol abuse; to evaluate the purported protective effect of moderate amounts of alcohol in heart disease; to elucidate the role of ethanol (as distinct from such confounding factors as cigarette smoking) in the occurrence of fetal alcohol syndrome; to explore differences in alcohol use and abuse among various population subgroups; and to assess the role of the family in the occurrence of alcohol abuse, perhaps through longitudinal studies of children of alcoholics. This last type of study might help clarify the role of genetic predisposition to alcohol abuse. All of these studies should be complementary to basic biological research.

A second major opportunity for research is the natural history of alcohol-related diseases, such as liver cirrhosis and pancreatitis. The "energy wasting" effect noted in some animal studies and in chronic alcoholics might be explained through metabolic studies.

Other necessary and timely studies identified by the panel include the diverse effects of ethanol intoxication and withdrawal, and the development of suitable animal models for the study of pancreatitis and other clinical consequences of alcoholism.

Panel 4: Psychosocial Issues

The consumption of alcoholic beverages pose questions that are fundamental to the understanding of psychological and social behavior, just as alcohol-related questions are basic to the extension of knowledge about biological processes.

At the societal level, drinking behavior is related to the technology and norms of particular cultures, to the organizational, economic, and political characteristics of societies, and to the roles assumed by individuals within their social networks. These factors determine the extent to which individuals are exposed to the risk of developing drinking problems.

At the individual and cellular level, alcohol's pharmacological and nutritional properties interact with the structural, functional, chemical, genetic, and psychological characteristics that human beings tend to have in common as well as the characteristics and combinations of traits that are individually unique. Study of the interplay between the unique drinking capacities, motivations, and experiences of individual persons and the normative drinking values, customs, beliefs, and sanctions of social groups is basic to the study of drinking behavior.

For individual persons, alcohol is valued as a mood-modifying drug, a medicine, a sanctifying substance, a source of food or of personal energy; for societies alcohol serves all of these functions and more, including a form of fuel for industrial energy, a major economic commodity, and a significant source of tax revenue. The problems posed for individuals are intoxication, disease, drug dependency, and their consequences; for societies, the problems involve family and public safety and health, loss of economic productivity, moral and legal conflict and constraint, and a clustering of alcohol problems with other major forms of social pathology.

The two major areas of opportunity highlighted by the Panel on Psychosocial Issues are research on consumption of alcoholic beverages and risk factors for alcohol abuse.

Studies of consumption should look at factors that underlie the rise in *per capita* consumption, the relation between consumption and changing economic conditions, the impact of relative price of alcohol on patterns of consumption, the significance to consumption of changing organization and strategies in the alcohol beverage industry, the impact of media messages, the relationship of alcohol consumption to that of other chemical substances, and the relationship between consumption and changing factors of social values and social policy.

Studies of populations at risk should assume variations in individual risk levels. Research is needed to identify situational factors that serve to support or restrain at-risk drinking. Specific questions relate to the role of the family-centered socialization process in the development of alcohol problems, the role of work-related socializing experiences and other work-related factors of exposure, the social supports for heavy drinking and how they are accepted or rejected, and the role of drinking in relation to other problems such as accidents, violence, or crime.

Panel 5: Prevention Issues

According to the Panel on Prevention Issues, alcohol abuse has biological, psychological, and social origins. The public health model considers these from three perspectives: that of the host, the agent, and the environment. By modifying the supply or the demand for alcohol at each level--host, agent, and environment--prevention efforts aim to reduce or eliminate abuse of alcohol. Prevention strategies at each level aim to diminish the detrimental effects of acute or chronic abuse of alcohol as well.

Early identification of target populations at risk requires a better understanding of the natural history of alcoholism for diverse groups and the development of appropriate screening tests. All people may be regarded as potentially susceptible to adverse outcomes from alcohol consumption, but some may be more susceptible, on genetic or or other grounds, than others. Identification of risk factors, risk groups, and target populations should facilitate the design of effective and timely preventive interventions, as might biochemically oriented studies using high-risk individuals. Biochemical screening tests might derive from the research on metabolic pathways, neurotransmitters, and membranes mentioned earlier. This research also might clarify the role of inheritance in the etiology of alcohol abuse and its various clinical complications. Available psychological screens must be studied to determine not only their suitability and adaptability to diverse groups, but also to improve their effectiveness in detecting early signs of abuse. Examination of individual coping mechanisms may also prove a promising screening tool.

The relationship between price and consumption, the effect of taxation policy, and the utility of legal constraints (drinking age, zoning, hours of operation, and others) may be viewed as prevention studies with respect to the agent. Liver cirrhosis decreased after the legislation of Prohibition, but the effect of decreased consumption on other complex alcohol-related problems is not as clear-cut and merits further study. Longitudinal studies are needed because responses to a given change in availability or access may vary with time--an effect may develop slowly, or an early effect may not be sustained. Research on control measures limiting availability or reducing demand primarily involves the study of effects of a given change in policy upon the amount of alcohol consumed and the frequency of alcohol-related problems. Such research often must take advantage of "natural experiments" resulting from local changes in zoning laws and the like rather than being conducted as "controlled" experiments. However, the aggregate of information might reveal effective ranges for such measures--price increases that limit consumption but do not stimulate illegal production of alcohol, for example. This research could lead to rational social management strategies to reduce availability--by zoning laws, for example--or to decrease demand--by label warnings or strict enforcement of driving-while-intoxicated laws, for example. The reader is referred to the report of a study of the Assembly of Behavioral and Social Sciences of the National Academy of Sciences, National Research Council for a detailed analysis of "Alternative Policies Affecting Prevention of Alcohol Abuse and Alcoholism."

Study of the environment in which drinking occurs, including the social contexts that influence the initiation and pattern of drinking, has great potential for revealing strategies for prevention. Environments that may help shape an individual's use of and response to alcohol include the family, the workplace, and the educational system. Exposure to the mass media with their implicit and explicit messages about alcohol, also may have great influence. The deterring and promoting elements that these sources of information impart need to be understood better. Because work, family, and other environments may give conflicting messages, research is needed on ways to strengthen the factors that forestall problem drinking.

Existing knowledge in the behavioral sciences should be reviewed for lines of research with potential applicability to research related to prevention of alcohol abuse. For example, the Stanford Three Community Study on risk factors for cardiovascular disease successfully stimulated changes in individual behavior with regard to smoking and diet such that a reduction in risk factors for cardiovascular disease was achieved in the experimental communities. The methodology of this study, which included use of the media with or without supplementation by individual counseling for a high-risk group, may provide valuable guidelines for alcohol-related research.

The interaction between biomedical and behavioral factors, such as stress effects on the neuroendocrine system, should be investigated. Studies comparing children of alcoholics and non-alcoholics for drinking patterns and for behavioral and other psychological problems also are needed--especially those including successful children of alcoholics.

Panel 6: Treatment Issues

Alcoholism treatment research has traditionally consisted of at least three separate components: outcome monitoring, which determines what happens to patients who enter an alcohol treatment program, but provides little direct information on whether the treatment program caused the observed outcome; studies of treatment efficacy, which attempt to control for all extraneous factors to determine whether the outcome was the result of the intervention being studied and thereby provide insight into mechanisms of change; and investigations into access to care, which seek to identify factors that encourage or discourage individuals from entering treatment regardless of its efficacy.

Many treatment programs currently conduct some form of outcome monitoring, usually by attempting to measure attributes of persons entering care, by defining the treatment regimen being offered, and by following up a group over a period of a year or so. From the point of view of comparing treatment modalities, however, such efforts often are flawed in their initial design and deficient in follow-up procedures, so that the observed patient outcomes may be unrelated to the treatment.

The goal of efficacy studies is to establish treatment modalities that offer patients maximum benefit at minimum risk. Benefits and risks are determined by well-designed clinical trials that evaluate a promising treatment in comparison with an accepted standard treatment. Criteria for success must be stated in objective, easily measured terms: medical problems are only one aspect in alcoholism/abuse; others include difficulties with police, interpersonal relationships, and job functioning. There are many combinations of treatment aspects and patient characteristics, and they must be either accurately measured or closely controlled to conduct treatment research adequately. Present fiscal and administrative limitations make this type of research exceedingly difficult. But such research is necessary to develop cost-effective, rational therapies. One suggested approach is to develop one or more centers devoted exclusively to such studies, much like a British Medical Research Council unit. Another possibility is to encourage one or more of the existing Alcohol Research Centers to expand their efforts in this area. Finally, an intramural program devoted to treatment studies might be undertaken jointly with a government agency relevant to the problem, such as the Veterans Administration, using a multicenter model such as has proven successful in clinical trials in others areas of medicine.

The Panel on Treatment Issues identified the inadequacy of most current attempts to measure the efficacy of various treatment regimens as the major research opportunity in this area. Well controlled clinical trials using modern biostatistical approaches are the primary need. Better methods of measuring efficacy would permit an array of studies to seek correlations between patient characteristics and outcomes for a given regimen, or to determine whether matching patients and regimens for certain variables improves outcome. Better efficacy measures would facilitate comparisons among different treatment settings and levels of personnel training, treatment approaches, educational approaches, levels of involvement of the court system, and goals of treatment. A coordinated series of studies in which designated variables are controlled should lead to a knowledge of the mechanisms of change, and thus to design of more effective treatment processes.

A second principal area of opportunity, the panel concluded, is in assessing access to treatment and the factors that contribute to the decision to enter care. Various barriers to treatment--employer attitudes and policies, attitudes of family and friends, availability of insurance coverage for treatment programs--should be evaluated.

Among the other research opportunities noted by the panel are studies of the distribution of individuals in need of treatment, especially population subgroups, such as hospitalized persons. Various aspects of the roles of education and the courts in treatment need evaluation. Finally, factors in the natural history of alcohol use that ameliorate or exacerbate alcohol problems or that favor or hinder "spontaneous" remission need to be examined.

Economic Costs: Research Opportunities

In allocating research dollars, explicit and implicit choices are made among priorities, costs, and potential benefits of various alternatives. Although the problems of alcohol use are not simply economic problems, economic analysis can provide a useful frame of reference for measuring them and gauging the effectiveness of efforts to alleviate or mitigate them.

Research should be conducted on the methodology of assessing the various societal costs imposed by alcoholism and alcohol abuse. More precise measures of the costs of alcoholism and alcohol abuse could improve evaluations of the impact of various programs and policies. More precise estimates of benefit/cost ratios of additional research programs, in alcohol-related problems and other disorders, could help to establish priorities among illnesses, and to determine the optimal total research effort for alcoholism and alcohol abuse. A detailed analysis of research funding and trends in costs requires that choices be made on emphasizing alcoholism as a disorder or of focusing on the problems that attend continued abuse of alcohol.

Studies of the fiscal relationship between the alcohol beverage industries and the various levels of government should be conducted. Excise taxes, license fees, and other taxes and charges on alcoholic beverages together comprise a substantial source of revenue to state, local, and federal governments--about $10 billion in 1976.

Recurrent Themes

Despite the separation imposed by the panel structure, it is clear that research areas often overlap and several themes recur. Prominent among these are biochemical/genetic issues, including the structure and function of membranes. The utility of studies of natural history of alcoholism and its complications, and the special opportunity presented by natural experiments, are reiterated by several panels as well.

Evidence is accumulating that many health problems result from an interaction between extrinsic factors and factors unique to an individual, including genetic endowment. The panel reports noted that some people may have a genetic susceptibility to problems with alcohol or particular complications of its abuse—children of alcoholics, for example—while others may be "protected" by their genes—for example, orientals with the flushing response. Many questions remain about the relative contribution of genetics and the environment--especially the social environment--and several avenues of investigation have been suggested by the panels. Genetic/biochemical studies of the enzymes and pathways of alcohol metabolism, the structure and composition of membranes, or changes in neurotransmittters and their receptors may provide insight into the apparent differential susceptibilities and their possible genetic basis. By allowing genetic influences to be accounted for, such information should facilitate progress in identifying environmental factors that promote or deter development of alcohol-related problems. Such information should then facilitate design of effective screening tools and of preventive interventions and treatment programs.

A Program for the Future

It is clear from the preceding material that alcoholism is a serious problem affecting millions of people; that research investment in alcoholism is not commensurate with the burden of illness on any basis of comparison one chooses (research dollar per patient, per cost of illness, per industry dollar, per tax revenue dollar); that the research investment in alcoholism is not commensurate with the research effort mounted against other major diseases; and that significant research opportunities exist in biomedical, psychosocial, and behavioral areas, all suggesting strongly that an enhanced research investment may have practical yields.

The committee has identified major research opportunities in each of the specific disciplinary areas investigated, and also in analyses of research dollar allocation. Certain disciplines offer particularly exciting prospects at this time, but the committee does not believe that any area can be ignored.

There are choices to be made in the organization of the research effort. Are there ways to support research that are not being effectively used? Are our current resources being used wisely? What are effective ways to foster good research in this area? How do we attract talented investigators into this area? How may the results of research programs in alcoholism be translated into practical programs directly benefiting the afflicted?

The committee believes that the pattern of biomedical research support developed in this country since the 1950s has proved its effectiveness. Consequently, the effort in alcohol-related research should be peer-reviewed, investigator-initiated research grants.

The NIAAA and ADAMHA have reorganized the research review process and have administratively separated grant review from grant management, review now being more analogous to that in the NIH Division of Research Grants (DRG), as was recommended by the President's Biomedical Research Panel (1976) 20/ and by the President's Commission on Mental Health (1978) 21/. While some might favor even more separation of the alcohol research review process from alcohol grant management, such as delegation of all reviews to NIH-DRG Initial Review Groups, others voice the justifiable concern that the needs and complexities of alcohol research could not be met by any existing DRG panel.

The relatively small number of active researchers in alcohol-related problems (Federal Support of Research in Part II) causes the potential population of qualified reviewers to be limited. Further, despite the small number of researchers, a frequently voiced complaint is that well trained scientists in other areas avoid entering the field of alcohol research because the tight dollars make awards highy competitive and the review panels tend to perpetuate a crony-istic tradition which excludes novel approaches and which ignores previous meritorious work in other areas. Among many scientists, the field of alcohol studies has a reputation of extreme variability and questionable solidity--dramatic claims of experimental breakthroughs are rarely replicated by others--all of which gives the field of a soiled cloak of respectability.

In approaching such concerns, NIAAA and its critics both must strive for solutions. Concerted effort is needed to develop research frameworks suitable for the practical concerns of alcohol use and flexible enough to accommodate questions and experimental strategies. NIAAA should be supported and encouraged in its efforts to assemble high-quality, scientifically sound review panels. In addition, since the NIAAA council is heavily involved in many non-research areas, a special scientific advisory group assisting the Director of NIAAA would be helpful in providing scientific advice and guidance.

NIAAA receives many research proposals of high quality, a good number of which cannot be funded (less than one-third of approved grants are funded). We call for greater dollar investment in alcoholism research. If the current research budgets were doubled, it would still be too little. The Committee believes that increasing current research budgets by 50 percent in each of the next three years might begin to make the desired impact.

There is a need to stimulate more investigators to enter the field and to bring into the field scientific expertise developed in other biomedical and behavioral sciences. Making more dollars available for traditional investigator initiated (RO1) grants is one very effective way of stimuating scientific interest, but there also are other methods. One is the intramural research and training program; another is the developing alcohol research centers.

The categorical institutes of NIH have had well-developed intramural research programs that have only pale reflections in NIAAA. It might be worthwhile to consider some of the unique and positive features of intramural research in alcoholism. The arguments for strong intramural research programs are:

1. Quality research can be performed efficiently. Because the intramural institutional effort is restricted to research, there are few distractions. Quality is ensured by careful selection of research personnel and by periodic review. A standard is set that influences the research effort beyond the institutional walls, a true catalytic effect.

2. The intramural research program serves as a training site for beginning investigators.

3. The research can be focused on socially relevant problems; skillful and well-informed research directors can alter research priorities as needs become apparent.

4. The scale of research can depend on the problem investigated. Team efforts can be more quickly mounted than is possible in an academic setting. Consensus meetings and other state-of-the-art conferences are readily organized.

The last two arguments are especially relevant to a proposal to strengthen intramural research programs at NIAAA, perhaps uniquely for this institute compared with categorical institutes of NIH. Especially for treatment and prevention, we need organized, high quality research studies. Individual investigators working in scattered institutions across the United States usually are not well equipped to organize the kind of large-scale, epidemiologically-based approach that is necessary to those studies. Treatment trials are difficult to organize, are expensive, and require continuity of effort. Research in promoting healthful changes in behavior at the community level is even more complicated and expensive. Expanded intramural research efforts in alcoholism might therefore emphasize areas of research that cannot be readily approached with the traditional R01-type grant.

The committee therefore calls for expanded intramural research programs in NIAAA*, and sees particular merit in epidemiologic, prevention, and treatment research programs. Success in this area can only be achieved if adequate arrangements can be made to provide access to large numbers of subjects. As discussed in the Treatment Panel report, mechanisms other than an expanded intramural effort in treatment research merit serious consideration. These include the development of an MRC-like unit devoted to treatment research, a collaborative effort using a multi-center approach in cooperation with the Veterans Administration or the military services, or development of one of the existing Alcohol Research Centers to stress treatment research.

Alcohol Research Centers were conceived in an effort to inject vitality and visibility in alcohol studies, and foster development of research in the field. The committee believes that several alcohol centers, located across the country, represent a well-conceived plan. The committee believes that the Alcohol Research Centers have not yet been in place long enough, nor are well funded enough, to allow a decision as to their value as compared with putting the money into other modes of research. The principle of establishing securely funded research units, engaging carefully selected investigators in academic environments, is a sound one. It has the advantage of identifying productive, creative investigators who have the talent and the energy to establish a significant presence in alcohol studies. These centers could be the focal points for bringing new talent to the field. Those centers which have been most successful in establishing a recognized presence in the alcohol field should be encouraged financially; centers that do not rise to excellence should be permitted to wind down.

The committee believes that for the alcohol centers to succeed in promoting alcohol investigations, they must have a greater amount of financial support than they have enjoyed up till now and a greater assurance of grant continuity. Any advantage of an alcohol center is dissipated if there is no long-term commitment of funds to allow planning over a period of a few years. We suggest that alcohol centers be given a committed level of funding for five-year periods, rather than the current practice of yearly budget negotiations. We believe that it is better to have a handful of well-funded alcohol centers rather than a larger number of impoverished units.

The VA approach, a relatively modest one of selecting a few investigators on a competitive basis and supporting their research programs in alcoholism, has been successful in attracting new people into the field. The Committee considers the VA approach to be well conceived and highly promising. The approach is worth continuation and expansion.

As these programs succeed in attracting new investigators into alcohol research, the problem of continuation funding of meritorious work in alcoholism becomes even more acute than at present. The current situation is not good. Only half of the submitted grants in alcohol studies are approved; less than one-third of the approved proposals are funded. (See Federal Support of Research in Part II.) With scarce resources, the natural response of study sections is to support already proved established investigators. Without deprecating established research workers, it is worth pointing out that it becomes very difficult for investigators new to the field to break into it. Yet a revitalization and expansion is exactly what is needed in this field.

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*Committee member Dr. Edith Gomberg does not endorse this recommendation. She states "The intramural research programs of NIH, already in place, are well developed, but the expenditure of limited research moneys on expanded intramural research in alcohol studies seems ill-advised at this time. Duplication of facilities and personnel of universities and research institutes should not have high priority. Existing universities and research institutes are capable of large scale, quality research with social relevance. The universities have served and still serve as training sites for new investigators."

Where are the increased funds to come from? While this question goes beyond the charge to the committee, we cannot help but notice that NIAAA devotes a relatively small percentage of its budget to research--about 10 percent in 1978. That year NIDA devoted about 14 percent of its budget to research, and NIMH devoted about 24 percent. It seems reasonable to suggest that NIAAA bring its research budget more in line with its sister institutes in ADAMHA and assume a lead position. Our earlier recommendation of a 50 percent increase in the research budget in each of the next three years would have the desired effect without necessarily increasing the total NIAAA budget to unacceptable levels.

There are also several aspects of the economics of the beverage industry that bear on this question. First, the alcohol taxing structure has not changed appreciably in many years. Consequently, alcohol today is a relatively cheaper commodity that it was in pre-inflationary times. A relatively small increase in federal taxes for alcoholic beverages can supply very substantial funds for research. We believe there is great merit in specifically taxing alcohol users for research in alcoholism. Secondly, the word "paltry" seems inadequate as a descriptor for the past degree of support by the industry of research related to alcohol problems. An industry with manufacturer receipts of some $16 billion and an $800 million taxable income in 1975 22/ might contribute in a substantial way to the effort to understand and hence alleviate the social and medical havoc associated with the abuse of its products. It is hoped that other companies will follow, however modestly, the lead set by Seagram with its recent $5.8 million grant for research.

Research in alcoholism can be cost effective. A dollar spent for developing useful prevention strategies can save many times that amount of money in subsequent health care costs, lost work time costs, and so forth. Alcoholism is just too costly to this country for us not to spend money on alcohol research.

This report necessarily directed its attention to the problems associated with alcohol in the United States of America. However, it is important also to bear in mind the world-wide nature of these problems. Two events at the World Health Assembly of 1980 held in Geneva, Switzerland highlighted the serious global difficulties. The World Health Assembly is the governing body of the World Health Organization; virtually every country in the world is represented.

Immediately prior to the World Health Assembly, a meeting was held to focus on ways in which the industrialized, technically advanced countries could improve the health of their populations during the remainder of this century. From the entire gamut of issues, alcohol-related problems were singled out for heavy emphasis. A second meeting, held during the Assembly, was attended by representatives of many countries, from every continent of the world, and was concerned solely with alcohol problems. In this instance, the main emphasis was on the heavy burden of illness, including social disruption, associated with alcohol use in developing countries. Thus, in 1980, vivid testimony has been given by the world's health leadership to the extraordinary scope and gravity of the problems considered in this report.

Summary Recommendations

The main scientific opportunities identified by the panels are summarized below.

Research on biochemical issues:

- Elucidation of the pathway(s) for alcohol metabolism, the physiologically significant consequences of its metabolism, and possible genetic variation in the metabolism that help explain differential individual responses to alcohol.

- Development of more appropriate animal models--including primates and cell culture systems--to assess alcohol metabolism, intoxication, tolerance, dependency, and toxicity.

Research on neuropharmacological issues:

- Investigation of the effects on cell membranes of acute and chronic consumption of alcohol--including studies of fluidity, lipid and enzyme composition, and transmembrane ion distribution.

- Investigation of the effects of acute and chronic consumption of alcohol on the concentration, turnover, localization, and action of neurotransmitters, and on adaptive changes in neurotransmitter receptors that may ensue.

Research on clinical and epidemiologic issues:

- Exploration of the link between use of alcohol and occurrence of adverse consequences, through epidemiologic studies, of variables such as psychological and behavioral disorders; ethnicity, gender, and genetic endowment; and family characteristics.

- Studies of the natural history of alcohol-related diseases such as liver cirrhosis and pancreatitis.

Research on psychosocial issues:

- Assessment of the influence on levels of alcohol consumption—and severity of associated problems—of such variables as price, industry marketing practices, use or abuse of other drugs, general economic conditions, and changing social values and policies.

- Identification of situational factors that affect at-risk drinking—including family and work-related socialization and social supports.

Research on prevention:

- Studies directed to early identification of those at risk—including natural history studies, genetic studies, development of biochemical and psychological screening tests, and examination of individual coping mechanisms.

- Determination of elements of the environment--such as mass media, community programs, and school, work, and family structure—that deter or promote abuse of alcohol.

Research on treatment:

- Development of administrative structures and outcome criteria to allow efficacy studies that would elucidate effective combinations of patient characteristics and treatment settings, approaches, and goals.

- Assessment of factors such as employer policies, insurance coverage, and family attitudes, that may influence access to treatment programs.

Research on economic costs:

- Improvement of methodology to assess societal costs imposed by alcoholism and alcohol abuse.

- Studies of the fiscal relationships between the alcohol beverage industry and federal, state, and local governments.

The Committee's additional recommendations regarding support of alcohol-related research are:

- There should be a substantially greater investment in alcohol research, with individual investigator initiated grants (R01) having highest priority for additional support.

- Some of the additional funding should be used to put the existing alcohol reseach centers on a more secure and stable footing, to allow them to realize their full potential. Furthermore, committed funding for the centers should be for longer intervals than one year—perhaps five years.

- An increased intramural effort also is called for with the programs targeted toward specific objectives not readily met by other approaches--such as epidemiologic, prevention, and treatment research programs.

- Substantial sums should be allocated for research in treatment modalities—perhaps as part of an expanded intramural program.

- A scientific advisory group should be formed to assist in providing scientific advice and guidance to the Director of NIAAA.

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EXPLANATION OF REPORT

Ms. WILLIAMS. This report, produced after an extensive review of the alcoholism area, the disease itself, its impact on society compared with our investment, concluded that alcoholism research receives a disproportionately low amount of funding compared to heart disease and cancer, the diseases which exceed it in morbidity and fatality.

They spend one-hundredth of the amount on cancer research and heart research relative to the cost-effect of the disease. It supports in part the proposals to shift management information responsibility for the servicing program to the States.

However, we will be advocating with the other committees an alternative to a block grant which will target a portion of those funds for alcoholism and distribute them among the States on the basis of population rather than existing programs.

NCA realizes the Federal Government need not provide an ongoing subsidy of treatment services in a period of making very difficult choices about the allocation of dollars for health and human service programs.

In conclusion, I would just like to say that there are very definite measurable benefits of these groups providing alcoholism information and help in the lives of people. There is documentation in the reduction of utilization of higher cost medical services, when alcoholism is detected early and treated appropriately.

In research programs, we have been able to identify specific populations at risk, for example, the children of alcoholics. Research has been very definite on the impact of alcohol on a fetus and the link is clearly established between the consumption of alcohol and a syndrome of birth defects called the fetal alcohol syndrome and other brain diseases of children.

Literally billions of dollars have been saved to private industry as a result of providing alcohol programs.

This concludes my remarks. I appreciate the opportunity to provide them for you.

Senator INOUYE. Thank you very much. How many alcoholics do we have in the United States?

Ms. WILLIAMS. The Federal Government estimates that there are approximately 10 million adults and 3.3 million adolescents who are alcoholic or experiencing severe health and physical problems as a result of their use of alcohol.

Senator INOUYE. What is the loss to our Treasury as a result of alcohol?

Ms. WILLIAMS. I am sorry?

Senator INOUYE. How much are we losing in the National Treasury as a result of alcoholism?

Ms. WILLIAMS. The Institute of Medicine report which I referenced earlier estimates that the total social and economic costs of alcoholism to this country could be as high as $60 billion per year. This includes unnecessary utilization of medical care, losses as a result of fires, accidents, and injuries; homicides; and other crimes, where there is an association with alcohol. As many as one-half of all automobile accidents and fatalities have been linked to the use of alcohol.

Senator SCHMITT. Mr. Chairman, I have just one question. One of the difficulties the subcommittee has had, I think it may not just be confined to us, is in figuring out how to effectively allocate resources for the application of research.

You certainly aren't going to get much argument from me about the value of knowledge, but it's hard for us to perceive demonstration that the Government-supported efforts in treatment and rehabilitation have really shown an effectiveness that warrants at least national funding.

There are some local centers that I am aware of in my own State, I am sure that Senator Inouye has some in his and others, where we can cite cases where there seems to be a very specific program. When you try to get a national picture, it doesn't look effective at all.

Do you have an explanation of that, say, relative to AA and other private places?

Ms. WILLIAMS. I am not sure that I agree that there is no indication that the program is effective. For example, the U.S. Postal Service put in place an employee assistance program. This program was—the economic impact of it was audited, I believe, on three different occasions. Each time, it confirmed the finding that for every $1 they had put into the service, $5 was returned to the Postal Service.

Senator SCHMITT. But that is not being funded out of this budget?

Ms. WILLIAMS. No; it is not funded directly from the Institute's budget. However, it is an example of how ideas and programs that are developed in a national program are applied in private and public programs throughout the country.

There are scores of other examples, and I will be more than happy to provide them to you.

Senator SCHMITT. We have had plenty of isolated examples of success. When we try to get a handle on the national statistics, success of the total alcohol abuse program, particularly, the expenditure of State and grant money, it is very difficult to decide or at least it has been difficult for me to get a demonstration that it's being effective nationally, even though there are excellent examples of where it has been effective.

You see the limit we are faced with?

Ms. WILLIAMS. What would be an example of a national indicator of success?

Senator SCHMITT. I would rather ask you that question, because we are looking for a way to be able to maintain those programs that have shown an effective effort against the disease of this kind. But in alcohol abuse, it's been very difficult for anybody to show the committee, since I have been on it, that this effort is any more effective than what AA and other private and more specialized activities are doing.

So we would appreciate anything you want to supply us with.

Ms. WILLIAMS. That I will.

Senator INOUYE. I should like to point out that Senator Schmitt is the chairman of this committee. If you can't convince him, you're in trouble. [Laughter.]

I would like to suggest that on alcoholism, maybe we have taken the first step. We have got the problem out of the closet, which is very important. And I think from there, we will go to the next step.

Senator SCHMITT. The Senator is correct. But it's been pointed out to me that among teenagers and women, at least, alcoholism seems to be on the rise. So we obviously have not caught up with the problem.

The question is, are we really putting the resources in the right place? That is the question. I agree with you about the cost.

We opened these hearings with my list of bad habits. If we could just get rid of those, we wouldn't need to have a Senate hearing. But we have the bad habits. How do we get to the solution?

So far, nobody has come up with a way of demonstrating that these resources, at least the State grant resources, overall on a national basis are being effectively applied, even though there are some great examples of very fine programs working extraordinarily well.

Thank you.

Senator INOUYE. The record will be kept open for about 1 week, and if you can provide us with the necessary information, I'm certain it would be very helpful.

Thank you very much.

Senator INOUYE. Our next witness is the director of the Center for Urban Affairs and Policy Research, Ms. Margaret T. Gordon.

STATEMENT OF MARGARET T. GORDON, DIRECTOR, CENTER FOR URBAN AFFAIRS AND POLICY RESEARCH

Ms. GORDON. I am the director for the Center for Urban Affairs and Policy Research at Northwestern University in Evanston, Ill. I am also chairing the National Advisory Committee to the U.S. Secretary of Health and Human Services on the Prevention and Control of Rape.

My statement today also reflects the concerns of a significant proportion of the religious community, as represented by the Board of Global Ministries of the United Methodist Church, representing a lot of members.

I am here to illustrate three points: First, that rape is a heinous crime against all society. It affects not only the victim, but you, your wives, mothers, daughters, sisters, and friends as well. We must support those people and places where victims can turn for the kinds of help they need. Second, that if we are to maintain the advances to date in the prevention and control of rape, it is appropriate for federally supported services to be conceptualized to include technical assistance, outreach, and education for communities. Third, that social science research is producing knowledge needed to plan more effective services for victims and more effective educational programs for prevention and control. Now is exactly the wrong time to withdraw support from these research efforts, and to do so could cause previous efforts to be wasted.

Now let me support these three points.

One, rape affects all of us. Next to murder, rape is the most feared crime. Women are substantially more fearful than men, though they are the least victimized of every crime except rape. In the United States, 75 percent of women are afraid to walk alone on the streets in their own neighborhoods at night, and they are regarded as asking for trouble if they do so.

Rape, and the fear it induces in every woman—and in many men for their wives, sisters, and friends—is destructive of individual lives, because women voluntarily barricade themselves indoors, and destructive of communities, because the participation of isolated, fear-paralyzed citizens is lost.

The victimization surveys conducted through the U.S. census reported that 192,000 women were raped in 1979, an increase of 47,000, or 24 percent, over the 1976 figures. And it is estimated that since many victims don't report their rapes to anyone, these figures represent only 10 to 25 percent of the rapes that actually occur.

The 192,000 rapes represents 1.1 rapes per 1,000 women for only that 1 year. If a woman lives in a large city in the United States for 25 years, she has a 1-in-10 chance of being raped during that time.

In recent years, there has been marked improvement in the services available to victims. Treatment by police and hospitals has so improved in the large cities that victims are much less hesitant to report the crime. As a result, some believe the rate of rape has not increased, but rather only the rate of reporting rapes.

Victims in many cities are now able to get help from rape crisis centers, women's centers, churches, and community mental health centers. However, too often provision of service is dependent on volunteers who are burning out. They need your support.

I agree with those who say that the $6 million authorized in section 602 of the Mental Health Systems Act for fiscal 1981 and the $9 million authorized for fiscal 1982 for services to victims are a drop in the proverbial bucket—$100 million is more like what's needed to fully serve victims. But I most wholeheartedly disagree with those who then say that since those funds are not enough to do the job well, the money would be wasted if spent on services. Instead, what is needed is a reconceptualization of services appropriate for the Federal Government to provide, given an existing base of local-level volunteer services.

This leads to my second point.

If we are to maintain the advances made to date and use what we have learned about how to prevent and control rape and provide services, there must be federally supported technical assistance, outreach, and educational services to target populations and communities.

The $6 million for fiscal year 1981 and $9 million for fiscal year 1982 are sufficient for several services which would supplement those of existing volunteer-based efforts and reduce some of their considerable burdens.

These minimal funds could be best used in two ways: First, for demonstration of types of services needed but not yet provided to specific target groups—for example, families of victims—or in places as yet unserved. Second, for provision of technical assistance, outreach, and education services to target groups and communities where there is the desire to implement programs but where there is need for films, pamphlets, workshops, and other expertise which have proven effective with target groups elsewhere. One subpopulation frequently mentioned is primary and secondary schoolteachers who have requested help in dealing with the topic of rape.

And now for my third point.

There is a need, despite what some may argue, for continued social science research in this field. We have learned a great deal in the 5 short years since the National Center for the Prevention and Control of Rape was established at National Institute of Mental Health.

We have learned about motivations of convicted rapists. We have learned that victims experience predictable stages of emotional response, and we have identified appropriate supports at each stage. We have learned that some tactics have enabled some women, though attacked, to avoid victimization. We have learned about factors which enhance the likelihood of conviction in rape cases. We have identified effective strategies for educating children to avoid molestation, and a host of other findings.

But just as cancer researchers were not able in 5 years to isolate all the crucial determinants of that feared disease or develop prevention programs, so we have not yet isolated all the crucial determinants or developed and evaluated the best programs to prevent and control rape. Now—when we are on the edge of important breakthroughs and have developed a critical mass of scientists striving toward the same goal—is exactly the wrong time to stop.

Further, it is appropriate that this research should be managed and coordinated at the Federal level. The National Center for the Prevention and Control of Rape, currently authorized under Public Law 96-1367, title VI, section 601, has developed several constituencies making use of the findings of the research they have sponsored to date. These range from journalists and schoolteachers to volunteers in rape crisis centers and in the churches, and to academics working on models of coping.

I urge you to appropriate the full $6 million and $1.5 million authorized in the Mental Health Systems Act, section 601, for both fiscal years 1981-82.

Social science is giving us the information we need to correctly identify the needs and design the effective prevention programs. I know that many of you get impatient with the amount of time it sometimes takes to develop knowledge in areas where none now exists and that the rhythms of social science and academia are often out of sync with your needs as legislators and politicians.

But when impatient with our timing or desire to couch findings in qualified language, I ask you to consider the contributions of social science, the tools and concepts which have been absorbed into our conventional wisdom and public discourse, so that they are now common in our vocabulary, words such as "public opinion polls," "management by objective," "human capital," "acculturation," "political party identification," "cost-benefit analysis," "reference group," "target population," "evaluation and accountability," and many more. One recent article went so far as to attribute the success of Japanese industry to its application of social science findings.

In summary, I urge you all to be bold enough to commit yourself to a goal of eliminating rape. I hope you will stop the transfer of funds from social programs to the military, and I urge you to appropriate the full amounts authorized in the Mental Health Systems Act for both sections 601 and 602 for fiscal years 1981-82. These amounts will allow the maintenance of past gains and important additional progress toward both preventing and controlling rape and enabling communities to have the information and expertise they need to serve victims.

Law enforcement officials, mental health workers, and others with experience with populations under economic and work stress expect that violent crime and rape will escalate as aspirations are increasingly frustrated and people perceive the Federal safety net to be weaker and weaker. To deny these funds at this time would be tantamount to turning your backs on the women of America.

Senator INOUYE. I can assure you that we will not turn our backs on American women.

Ms. GORDON. Thank you.

Senator SCHMITT. I agree with that assurance. [Laughter.]

Senator INOUYE. I would hope.

Senator SCHMITT. I am not sure any of us would be safe if we turned our backs.

Senator INOUYE. Our final witness on this panel, Ms. Peggy Halsey, secretary of the Global Ministry for The United Methodist Church.

Ms. GORDON. She is not here and my statement reflected her concerns as well.

Senator INOUYE. Her statement will be part of the record.

I thank you very much.

[The statements follow:]

STATEMENT OF DR. JEANNE SPURLOCK

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, I AM DR. JEANNE SPURLOCK, DEPUTY MEDICAL DIRECTOR OF THE AMERICAN PSYCHIATRIC ASSOCIATION, A MEDICAL SPECIALTY SOCIETY REPRESENTING OVER 26,000 PSYCHIATRISTS NATIONWIDE. I AM PLEASED TO APPEAR BEFORE THE SUBCOMMITTEE NOT ONLY TO ADDRESS THE AMERICAN PSYCHIATRIC ASSOCIATION'S PARTICULAR CONCERNS, BUT ALSO THOSE OF THE AMERICAN ACADEMY OF CHILD PSYCHIATRY (A NATIONWIDE ORGANIZATION OF OVER 2,300 DOCTORS OF MEDICINE WHO HAVE COMPLETED BOTH GENERAL PSYCHIATRIC TRAINING PLUS TWO YEARS ADDITIONAL TRAINING IN CHILD PSYCHIATRY), THE AMERICAN ASSOCIATION OF CHAIRMEN OF DEPARTMENTS OF PSYCHIATRY (A NATIONAL ASSOCIATION REPRESENTING OVER 125 ACADEMIC DEPARTMENTS OF PSYCHIATRY IN THIS NATION'S MEDICAL SCHOOLS), THE AMERICAN ASSOCIATION OF DIRECTORS OF PSYCHIATRIC RESIDENCY TRAINING (THE ORGANIZATION REPRESENTING OVER 90 PERCENT OF THE MORE THAN 200 PSYCHIATRIC RESIDENCY TRAINING PROGRAMS IN THE NATION) AND THE AMERICAN SOCIETY FOR ADOLESCENT PSYCHIATRY (A NATIONAL ORGANIZATION OF 1,700 PSYCHIATRISTS WHO SPECIALIZE IN ADOLESCENT PSYCHIATRY) REGARDING THE PRESIDENT'S PROPOSED FY 1982 APPROPRIATIONS FOR THE ALCHOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

OUR INTERESTS IN THE DHHS APPROPRIATIONS FOR FY 1982 ARE WIDE-RANGING: FROM GENERAL FUNDING FOR MEDICAL EDUCATION, INCLUDING THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIPS, TO A DEEP AND ABIDING COMMITMENT TO RESEARCH INTO THE CAUSES AND TREATMENT OF MAJOR MENTAL ILLNESSES, TO NIMH CLINICAL AND RESEARCH MANPOWER TRAINING FUNDS, TO THE CONTINUED ESTABLISHMENT AND FURTHER DEVELOPMENT OF THE SERVICE DELIVERY SYSTEM WHICH PROVIDES A LOCUS FOR THE TREATMENT OF THOSE SUFFERING FROM NERVOUS, MENTAL OR EMOTIONAL DISORDERS IN GENERAL, AND FOR THOSE DEINSTITUTIONALIZED CHRONICALLY MENTALLY ILL CHILDREN AND ADULTS IN PARTICULAR. I WILL RESTRICT MY TESTIMONY TO NIMH PROGRAMS, NOTWITHSTANDING OUR INTEREST IN ALLOCATIONS TO A PANOPLY OF OTHER DHHS AGENCIES, SINCE I RECOGNIZE YOU HAVE ALREADY HEARD AND WILL CONTINUE TO HEAR FROM WITNESSES INTERESTED IN THESE PARTICULAR AREAS.

BEFORE I PROCEED TO DISCUSS THE PRESIDENT'S PROPOSED NIMH BUDGET FOR THE UPCOMING FISCAL YEAR IN DETAIL, I WANT THE COMMITTEE TO KNOW HOW VERY MUCH AWARE WE ARE OF YOUR CONCERN FOR EXPENDITURE CUTBACKS AND EFFORTS TO BALANCE THE BUDGET. WE SHARE THE NATIONAL CONCERN ABOUT THE NEED TO PROVIDE AN EFFECTIVE RESPONSE TO AMERICA'S INFLATION PROBLEMS. ALL OF US WANT TO DO OUR FAIR SHARE TO ACHIEVE ECONOMIC RECOVERY, AND NONE OF US ENJOY BEING LABELLED AS SELFISH.

HOWEVER, IT IS TIME TO SPEAK OUT AGAINST WHAT WE BELIEVE ARE SHORT-SIGHTED CUTS IN FEDERAL SPENDING.

I AM SORRY TO SAY THAT THE PRESIDENT'S PRESCRIBED ECONOMIC MEDICINE, BEING METED OUT IN OVER-ABUNDANT DOSAGES, CONSTITUTES A DANGER TO THE HEALTH OF THE AMERICAN PEOPLE. THE MUCH HERALDED "SOCIAL SAFETY NET," THE PRESIDENT HAS PROPOSED TO SAFEGUARD THE HEALTH AND WELLBEING OF THOSE UNABLE TO HELP THEMSELVES HAS NOT BEEN CAREFULLY WOVEN, AND THUS, IS FULL OF HOLES.

A CRITICAL ASSESSMENT SHOWS CLEARLY THAT THERE IS NO "SOCIAL SAFETY NET PROVIDED" FOR THE CHRONICALLY MENTALLY ILL, OR SEVERELY DISTURBED CHILDREN AND ADOLESCENTS. INDEED, THE BUDGET REVERSES THE MEDICALLY INDICATED NEED FOR COMMUNITY SUPPORT AND TREATMENT FOR THESE MOST VULNERABLE PATIENTS. AT THE SAME TIME, IT COMPELS STATES TO RETURN TO A PRIOR PATTERN OF INSTITUTIONALIZATION OR NEGLECT, REMANDING THE CHRONICALLY MENTALLY ILL TO THE CUSTODY OF THE BACKWARDS -- OUT OF SIGHT AND THEREFORE OUT OF MIND, AND CHILDREN TO A SYSTEM OF NON-CARE.

WE THINK IT IMPORTANT TO RECOGNIZE THAT CUTBACKS IN RESEARCH INTO THE CAUSES AND TREATMENT OF MENTAL ILLNESS, FUNDING OF NIMH CLINICAL AND RESEARCH MANPOWER TRAINING, AND MENTAL HEALTH SERVICE PROGRAMS NOT ONLY PERPETUATE THE PUBLIC'S FEAR STIGMA AND MISUNDERSTANDING OF MENTAL ILLNESS, BUT SHATTER, AT THE SAME TIME, THE HOPE FOR IMPROVED, COST-EFFECTIVE CARE FOR THOSE SUFFERING FROM MENTAL ILLNESS -- HOPE BORNE OF NEW SERVICE DIRECTIONS, RESEARCH BREAKTHROUGHS AND INCREASED GENERAL AND CHILD PSYCHIATRIC PERSONNEL TO MEET AN IDENTIFIED SHORTAGE. MOREOVER, THESE CUTS FAIL TO ADDRESS THE PROBLEMS OF INFLATION PER SE. INSTEAD, THEY CONSTITUTE A PHANTOM COST SAVINGS. THE FUNDS NOT EXPENDED FOR THE PROVISION OF SERVICES FOR THE TREATMENT OF MENTAL ILLNESS, WILL INSTEAD FUND THE INAPPROPRIATE PLACEMENT OF THE MENTALLY ILL WITHIN THE MORE COSTLY CRIMINAL JUSTICE, GENERAL HEALTH CARE OR WELFARE SYSTEMS, AND THE RETURN OF THE CHRONIC PATIENT TO THE MORE EXPENSIVE, LESS APPROPRIATE STATE FACILITIES. SIMILARLY, CHILDREN ARE CHANNELED INTO WHATEVER MENTAL HEALTH SETTINGS ARE AVAILABLE, USUALLY THOSE IN-PATIENT FACILITIES WHICH ARE MORE COSTLY AND OFTEN INAPPROPRIATE. THUS, THE PURPORTED SAVINGS WILL ACTUALLY HAVE A SEVERE NEGATIVE IMPACT IN BOTH ECONOMIC AND HUMAN TERMS.

TO PUT THE MAGNITUDE OF THESE FALSE SAVINGS INTO PERSPECTIVE, THE COMMITTEE SHOULD UNDERSTAND THAT I AM SPEAKING OF AS MANY AS 20-32 MILLION

CITIZENS OF THIS COUNTRY WHO ARE IN NEED OF TREATMENT FOR MENTAL ILLNESS, WHO WILL GO UNAIDED; TWO MILLION PERSONS WHO HAVE BEEN OR WOULD BE DIAGNOSED AS SCHIZOPHRENIC, WHO WILL RECEIVE NO CARE; TWO MILLION WHO SUFFER FROM PROFOUND DEPRESSIVE DISORDERS; AND MORE THAN ONE MILLION WITH ORGANIC PSYCHOSES OF TOXIC OR NEUROLOGIC ORIGIN AND OTHER PERMANENT DISABLING MENTAL CONDITIONS, WHO WILL REMAIN WITHOUT TREATMENT. I AM SPEAKING OF AS MANY AS 25 PERCENT OF THOSE ELDERLY WRITTEN OFF AS SENILE WHOSE CONDITIONS ARE ACTUALLY MISDIAGNOSED MENTAL ILLNESSES WHICH COULD BE DIAGNOSED, TREATED AND OFTEN REVERSED. AND WORSE, I AM SPEAKING OF MORE THAN 9 MILLION CHILDREN IN THIS COUNTRY WHO SUFFER FROM SOME EMOTIONAL DISORDER AND OF WHOM FEWER THAN 10 PERCENT RECEIVE TREATMENT.

NIMH BIOMETRY DIVISION DATA INDICATE THAT MILLIONS OF DOLLARS ARE LOST EACH YEAR AS THE RESULT OF THE LOST PRODUCTIVITY OF THE MILLIONS WITHIN OUR WORKFORCE SUFFERING FROM SOME FORM OF MENTAL ILLNESS, AS WELL AS THOSE CHILDREN AND ADOLESCENTS WHO HAVE BEGUN THEIR OWN DESTRUCTIVE CYCLE OF SCHOOL FAILURE. WHEN WE FACTOR IN THE INDIRECT COSTS ASSOCIATED WITH MENTAL ILLNESS: PARENTS REMAINING HOME WITH AN EMOTIONALLY DISTURBED CHILD; SUICIDE IN A FAMILY; INAPPROPRIATE PHYSICAL HEALTH CARE INTERVENTIONS, THIS NUMBER IS MULTIPLIED MANYFOLD.

HOWEVER, WE CANNOT BEGIN TO SAVE THESE DOLLARS, UNLESS OTHER DOLLARS -- MANY TIMES LESS THAN THE COST IN HUMAN COINAGE -- ARE SPENT ON THE RESEARCH, TRAINING AND SERVICES NECESSARY TO ASSURE THAT THOSE SUFFERING FROM MENTAL ILLNESS RECEIVE TREATMENT.

THE NIMH MANPOWER SYSTEM IS THE KEY TO PROVIDING QUALITY MENTAL HEALTH CARE. IT PROVIDES THE TRAINED PROFESSIONAL RESOURCE WHICH, AREMED WITH THE NEWEST RESEARCH RESULTS, PROVIDES THE CRITICAL MEDICAL AND PSYCHOLOGICAL INTERVENTION AND CARE FOR THOSE SUFFERING FROM MENTAL ILLNESS. THE NIMH TRAINING BUDGET PROVIDES SUPPORT FOR THE FOUR CORE DISCIPLINES (PSYCHIATRY, PSYCHOLOGY, PSYCHIATRIC SOCIAL WORK AND PSYCHIATRIC NURSING), AS WELL AS PARAPROFESSIONALS AND RESEARCHERS. MOREOVER, THE SYSTEM TRAINS THE PRIVATE CARE PHYSICIAN AND GENERAL MEDICAL STUDENT NOT ONLY TO RECOGNIZE AND REFER THOSE SUFFERING FROM MENTAL DISORDERS FOR APPROPRIATE TREATMENT, BUT ALSO TO DETECT, DIAGNOSE AND MANAGE THOSE PROBLEMS IN THE GENERAL HEALTH CARE SETTING.

THE OMB RECOMMENDED NIMH TRAINING BUDGET DECREASE OF 50 PERCENT WILL NOT PERMIT THE REQUISITE NUMBERS OF APPROPRIATELY TRAINED PSYCHIATRISTS -- A MEDICAL SHORTAGE SPECIALTY -- TO BE ACHIEVED. SUCH IS IRONIC, SINCE THE REPORT of ADAMHA to this Committee, mandated by the Committee in its efforts to secure firm data regarding the ADAMHA Administrator-identified shortage of psychiatrists, underscored the specific personnel problems in both general psychiatry and child psychiatry. It specified both the actual present shortage (in both number and distribution) of psychiatrists and the potential future problems arising from the decrease in number of American Medical Graduates (as well as Foreign Medical Graduates) entering psychiatric residency training programs. Not only did that report point out the need for more active support of recruiting efforts, but better support for psychiatric residency training programs themselves.

The OMB budget proposes to phase out training support at the very time that further confirmation of this absolute shortage of psychiatrists has been made public by GMENAC and the Rand Corporation. GMENAC specifically cited only four of all medical disciplines to be in shortage -- among them both general psychiatry and child psychiatry. That report cited a need for no fewer than 38,500 general psychiatrists and 8,000 - 10,000 child psychiatrists by the year 1990. Today there are approximately 24,000 general psychiatrists and 3,000 child psychiatrists in the United States. The Rand Corporation noted that there is a serious shortage of trained psychiatrists to meet the need of our increasingly larger aging population, and that by 1990, there would be a need for no fewer than the full-time equivalent of 1,440 geropsychiatrists and at least 700 to fill faculty positions to train future generations of geropsychiatrists.

Moreover, the cuts come at the very time Federal law has altered the NIMH training program from a grant-in-aid program to students and their institutions to a new statutory loan-scholarship program requiring service payback, patterned after the NHSC scholarship program. This program would assure that once trained, psychiatrists and non-physician mental health professionals would provide care in otherwise underserved or unserved areas and settings -- a commitment identified by OMB Director Stockman in his "black book." Yet, a 50 percent cut in this program is simultaneously proposed.

Coupled with the proposal to further curtail the limited numbers of psychiatrists and other non-physician mental health professionals who now render care to the mentally ill, OMB proposes to amalgamate the existing network of community-based mental health service programs into a block grant program, consisting of all current categorical health programs, to be administered by the separate

STATES. THE ARGUMENT IS THAT SUCH BLOCK GRANTS REDUCE OVERHEAD COSTS, BUT IT DOES NOT TAKE INTO ACCOUNT THE FACT THAT THE STATE LEVEL DOES NOT AT THIS TIME POSSESS THE TECHNICAL EXPERTISE TO ADMINISTER THESE COMPLEX PROGRAMS, SINCE THEY HAVE RARELY BEEN HELD ACCOUNTABLE FOR THE COMPLEX MANAGEMENT AND REPORTING FUNCTIONS NOW CONDUCTED AT THE FEDERAL LEVEL. THE APPROACH ALSO FAILS TO TAKE INTO ACCOUNT THE TRADITIONAL "STEP-SISTER" ROLE THE TREATMENT OF THE MENTALLY ILL HAS TAKEN TO OTHER HEALTH PROGRAMS AT THE STATE LEVEL. ONLY THROUGH CONCERTED EFFORTS HAS MENTAL HEALTH BEEN INCLUDED IN THE SLATED-FOR-DEMISE HEALTH PLANNING LAW, THE EDUCATION FOR ALL HANDICAPPED ACT, AND MANY OTHERS AT THE FEDERAL LEVEL, AND THE HISTORICAL INATTENTION TO THE PLIGHT OF THE MENTALLY ILL AT THE STATE LEVEL HAS BEEN SIMILARLY DOCUMENTED IN STATE LAW AND STATUTE.

BY FUNDING A BLOCK-GRANT PROGRAM AT 75 PERCENT OF FISCAL 1981 TOTAL LEVELS, OMB WILL ESSENTIALLY BE ASSURING THAT THE GENERALLY LOW PRIORITY GIVEN TO THE TREATMENT OF THE MENTALLY ILL AT THE STATE LEVEL NOT ONLY WILL CONTINUE, BUT WILL PROBABLY BE FURTHER DIMINISHED AS LOCAL PROGRAMS COMPETE FOR FUNDING AT THE STATE LEVEL. (HISTORICALLY, FEW ARGUE FOR BETTER MENTAL HEALTH TREATMENT OPPORTUNITIES AND PROGRAMS AS THE RESULT OF THE STIGMA OF MENTAL ILLNESS, AND SUCH INDIVIDUALS WILL BE DRIVEN BACK INTO THE CLOSETS FROM WHENCE THEY HAVE ONLY RECENTLY EMERGED.)

THE NET EFFECT WILL BE TO DEPRIVE THE MOST VULNERABLE OF OUR POPULATION -- THE ELDERLY, SEVERELY DISTURBED CHILDREN AND ADOLESCENTS, THE CHRONICALLY MENTALLY ILL -- FROM ACCESS TO CARE WHICH HAS LONG BEEN PROMISED, BUT HAS NOT TO THIS DATE, BEEN A REALITY.

IN OUR ESTIMATION, HOWEVER, THE MOST SHORT-SIGHTED CUTBACK OF ALL IS IN THE AREA OF KNOWLEDGE DEVELOPMENT -- BASIC RESEARCH -- WHICH SERVES AS THE BACKBONE, THE FOUNDATION, UPON WHICH BOTH TRAINING AND SERVICE PROGRAMS ARE BUILT. THIS DECLINE IN THE PURSUIT OF NEW KNOWLEDGE IN THIS CRITICAL FIELD WILL DOOM COST EFFECTIVE, IMPROVED TREATMENT AND PREVENTIVE MEASURES FOR THE MENTALLY ILL, BOTH YOUNG AND OLD, BOTH INSTITUTIONALIZED AND IN THE COMMUNITY.

APPROPRIATIONS OVER THE LAST FEW YEARS HAD BEGUN TO RESTORE THE RESEARCH CAPACITY OF THE NATIONAL INSTITUTE OF MENTAL HEALTH -- SERIOUSLY ERODED BETWEEN 1966 AND 1976 BY LEVEL BUDGETS AND INFLATION. THE 1980 BUDGET RESTORED THE RESEARCH FUNDING TO 80 PERCENT OF ITS BUYING POWER OF TEN YEARS AGO. INDEED, ADMAHA ITSELF NOTED THAT THE "RESEARCH BUDGET OF NIMH -- THE PRIMARY SOURCE OF

RESEARCH SUPPORT FOR MENTAL ILLNESS -- IS ONLY 4 PERCENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' ANNUAL $3.4 BILLION HEALTH RESEARCH EXPENDITURE."

IF THE NIMH RESEARCH BUDGET IS CUT AS OMB PROPOSES, IT WILL NOT ALLOW WORK ALREADY IN PROGRESS TO CONTINUE. WITHOUT ADEQUATE FUNDING OF THE RESEARCH BUDGET, MAJOR RESEARCH INTO MENTAL DISORDERS AND BRAIN CHEMISTRY, PSYCHOGENETICS, NEUROENDOCRINOLOGY AND NEUROBIOLOGY WILL NOT ONLY BE SEVERELY CURTAILED, BUT IT WILL ALSO ENSURE THAT RESEARCH INTO THE DEVELOPMENT AND EVALUATION OF THERAPIES, CHILD AND ADOLESCENT PSYCHOPATHOLOGY, SCHIZOPHRENIA AND DEPRESSION AS WELL AS BASIC STUDIES IN BOTH THE NEUROLOGICAL AND BEHAVIORAL SCIENCES WILL BE SERIOUSLY CURTAILED. THUS, PSYCHIATRIC CLINICIANS' ABILITY TO TREAT NERVOUS, MENTAL OR EMOTIONAL DISORDERS WILL BE DANGEROUSLY COMPROMISED. COST-EFFECTIVE TREATMENT METHODS WILL NOT BE NEWLY DISCOVERED, MUCH LESS APPROPRIATELY UTILIZED.

WHAT IS MOST TROUBLING IS THAT A CUT IN NIMH RESEARCH FUNDING DOES NOT PERMIT THE SAME NUMBER OF HIGHLY SOPHISTICATED RESEARCH ENDEAVORS TO BE FUNDED. THE EFFECT OF A 15 PERCENT CUTBACK IN ACTUAL DOLLARS (COMBINED WITH DOUBLE DIGIT INFLATION, THEREBY REALIZING A CUT OF OVER 30 PERCENT) WOULD BE TO PROHIBIT FUNDABLE PROGRAMS WITH HIGH RANKING BY NIMH FROM RECEIVING FUNDS. SINCE IT IS PARTICULARLY DIFFICULT IN MEDICAL RESEARCH TO KNOW JUST WHICH RESEARCH EFFORTS WILL LEAD TO HITHERTO UNHERALDED BREAKTHROUGHS IN KNOWLEDGE, THE FAILURE TO FUND OTHERWISE QUALIFIED RESEARCH EFFORTS MAY WELL RESULT IN SET-BACKS TO INNOVATIVE BIOLOGICAL, BEHAVIORAL AND PSYCHOPHARMACOLOGIC MEANS OF TREATING HITHERTO DIFFICULT PSYCHIATRIC ILLNESSES. AS WITH THE DISCOVERY OF PENICILLIN, OFTEN RESEARCH INTO ONE AREA HAS UNEXPECTED, HIGHLY BENEFICIAL OUTCOMES IN ANOTHER. TO TIE THE HANDS OF RESEARCHERS WITH THE BONDS OF FISCAL AUSTERITY IS LIKELY TO TURN THE KEY TO ONCE AGAIN LOCK THE BENEFITS OF SCIENTIFIC DISCOVERY AWAY FROM THOSE SEEKING RELIEF FROM PSYCHIATRIC ILLNESS.

WE ALL WANT TO ACHIEVE ECONOMIC RECOVERY FOR OUR NATION, BUT WE MUST SPEAK OUT AGAINST THESE INEQUITABLE CUTS IN FEDERAL SPENDING FOR A POPULATION WHICH DOES NOT OFTEN SPEAK FOR ITSELF. WE URGE YOU AND YOUR COLLEAGUES ON THE COMMITTEE -- MOST NOTABLY CHAIRMAN SCHMITT, WHO HAS BEEN A LEADER IN HIS CONCERN FOR THE PLIGHT OF THE MENTALLY ILL AND FOR BASIC RESEARCH -- TO OFFER AN AMENDMENT TO THE NIMH BUDGET WHICH CHARTS AN APPROPRIATE COURSE BETWEEN THE NEED FOR FISCAL RESTRAINT AND THE NEED FOR ADEQUATE PSYCHIATRIC RESEARCH, TRAINING AND SERVICES AND PROVIDES THE INCREASES NECESSARY TO MAKE THESE PERSONNEL, KNOWLEDGE AND SERVICES AVAILABLE.

MR. CHAIRMAN, THIS CONCLUDES MY PREPARED TESTIMONY. I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MAY HAVE AT THIS TIME.

STATEMENT OF DAVID SANDLER

The National Council of Community Mental Health Centers represents over 750 community providers of mental health services spread throughout the United States. Community mental health centers are non-profit and provide free services for those who are unable to pay. The typical community mental health center has an annual budget of $2 million and 125 employees. In 1979, an estimated 2.4 million people, most of whom had annual incomes of less than $5000, received services in community mental health centers. The total number of patients with serious mental illness (schizophrenia and depression) receiving care at community mental health centers has increased and now accounts for 26 percent of admissions. From 1970-1975, admissions of individuals diagnosed as schizophrenic doubled in community mental health centers.

On February 3, 1963, President John Kennedy requested Congress' help in providing humane treatment for the mentally afflicted, and set this nation on a course to remedy centuries of neglect. As a direct result of President Kennedy's initiative, the federal government has already made an investment of over $1.5 billion in the community mental health program. Basically, we are asking this committee to continue this program which began 18 years ago and expand it to ensure greater access for those that have been underserved in the past.

In 1977, in response to the unmet needs of the mentally ill in this country, a Presidential Commission was formed to analyze our mental health system. After a one year study, the President's Commission on Mental Health reported that a substantial number of Americans do not have access to mental health care. This was especially found to be true for those who live in rural areas, small towns, and poorer sections of our large urban centers.

The study concluded that the nation needed to devote greater human and fiscal resources to mental health. The 12 percent of general health expenditures which is devoted to mental health was found not to be commensurate with the magnitude of the problem. The commission also recognized that most of the mental health dollars are being spent in large state institutions and in nursing homes, and concluded that there is an urgent need to further develop community based services. The commission recommended that this country continue to develop a national network of high quality, comprehensive, community mental health services. The recommendations were transformed into legislation which was overwhelmingly approved by Congress at the end of last year.

The National Council of Community Mental Health Centers strongly opposes the Administrations's proposal not to fund the recently enacted Mental Health Systems Act, P.L. 96-398, and to place mental health funding into a block grant. To do so would destroy the Federal/State/Local partnership in the planning, delivery, and funding of mental health services in the Systems Act that was approved by this body only a few months ago by a vote of 93-3. In previous community mental health center legislation, the federal government had bypassed the states in participating in the decision making and in the funding of community care. The Systems Act, however, turns almost all of the decision making authority over to the state, and Federal funds must go only to those projects which the state approves and ranks highest in priority. It is a long overdue piece of legislation that calls for the partnership that is requisite in order for there to be a true system of mental health care. The Administration's proposal ignores this piece of legislation, and merely changes the locus of control from the federal government to state government, thereby losing all opportunity for a real partnership.

The role of the states in mental health historically has been one in which the state serves as the primary institutional provider for the mentally ill. The history of this dates back to the time when Dorothea Dix made the demand for the states to create state hospitals for the mentally ill so that they could be treated more humanely. The public placed a great deal of pressure on the states to create the institutions outside of the communities in which the general population lived; namely, the state hospitals were built on farms away from towns and away from where people would have to interact with or see the mentally ill.

The quality of care in mental institutions has changed over the past several decades from what was once considered quality care to inferior care and treatment. The quality of care deteriorated as state institutions became overcrowded. They were staffed by professionals who often times were not able to pass state licensing Board examinations, who were trained in other countries, and who had a language other than English as their primary language. Consequently, many of the professionals were not even familiar with the culture and the mores of those they were treating. While many books and movies dealt with the poor treatment of the mentally ill, it was not until the late 1950's that there was a concerted national effort to change the directions of care.

In 1963, President John Kennedy spoke to the Congress and provided the concept of a "Bold New Approach" for the treatment of mentally ill individuals. This approach was to make treatment both accessible and available within the communities, and to provide a continuum of services. The states had been unwilling and unable to meet those needs and still focused on their own institutions which were developing into warehouses. The impetus of the Community Mental Health Centers Act of 1963 was to provide a national direction to the treatment and care of the mentally ill that would provide for the broad array of services that would respond to the needs of each individual who required treatment. The Administration's block grant proposal and budget cuts will lead us back to the time when patients were treated in state hospitals, and the comprehensive network of community programs will begin to unravel.

The Administration's proposal will result in higher costs of mental health care, and increased costs to our criminal justice system. By not properly treating those with mental illness or those that suffer from drug or alcohol addiction, we will only increase our welfare rolls and unemployment lines. With proper treatment, individuals who suffer from these inflictions can later develop into tax paying citizens without having to depend on the government for their survival for the rest of their lives.

There can be no question that both states and cities are experiencing the same kinds of economic pressures as the federal government. Some cities, such as New York, have approached bankruptcy. Others, such as Detroit and many midwestern cities, are facing severe economic pressures due to high unemployment rates. In addition, rural states have experienced financial stress due to droughts, poor crops, the economic food trade market, etc. The Administration's proposal to make block grants to the states, and cut these block grants by 25% below the 1981 appropriation level, will allow the states to control the life and death of these established Federal programs. In view of the tough economic times that states and cities are having, this proposal seems to be an abdication of the federal role and responsibility in a real federal/state/local partnership.

If the budget is cut and block grants are implemented, there is little doubt that patients that are currently being treated in the communities will return to the state hospitals for treatment. This is due to a variety of factors. The community programs for example, will not have the funds nor the staff to treat even the current patient load if there is a reduction in budgets and many patients will not be able to be seen and treated in the community. The public will want to remove the mentally ill from the community and return them to a place that is out of sight, namely the state hospitals. As stated earlier, this was the historical reason that the federal government got involved in mental health funding in the 1960s. Local and state politicians will be heavily influenced by the pressures of the public at large who do not understand, nor choose to tolerate, the mentally ill. Only during the last 15 years have there been major efforts to try and change the attitudes of the public through the community treatment models that have been implemented as a result of federal involvement and support. Budget cuts and block grants will return our nation to a time when the treatment and perception of the mentally ill will be one of getting the mentally ill out of sight and out of mind, and placing them in large institutions where they will become institutionalized and remain for long extended periods of time.

It is wrong to assume that states have the manpower and expertise to efficiently and effectively manage the entire mental health systems in their state without any federal assistance and oversight. It is a fact that in 1975 the California State auditor general conducted a study on the California mental health system and found that California wasted $12.6 to 25.1 million yearly because of improper management of its mental health program. This was immediately following Governor Reagan's administration in California. Consequently it is wrong to assume that a state can manage and be totally responsible for mental health delivery independent of federal cooperation and participation.

The Administration's proposal and its inevitable results will undoubtedly result in significantly higher cost to the public whether it be in federal tax dollars or state and/or local tax dollars. The important point is that the cost will be much higher to the public at large in tax dollars to support these patients in large institutions.

The cost of hospital care is staggering. In February, 1981, The Wall Street Journal reported that it cost the state of New Jersey $21,000 a year to treat a single patient in one of its state hospitals. This high cost was recognized in the 1980 Republican Party Platform which stated:

> "We endorse alternatives to institutional care. Not only is it costly but it separates individuals from the supportive environment of family and friends. This is especially important for the elderly and those requiring long term care."

Numerous studies have demonstrated that coverage of mental health services reduces utilization of other health services and the total cost of health care:

- In Texas, a longitudinal study (1973-1977) demonstrated that access for the elderly to needed treatment for mental illness resulted in a reduction in main lengths of stay in inpatient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than $1.1 million.

- Blue Cross of Western Pennsylvania assessed the medical/therapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings show that the medical/surgical utilization rate is reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved dropping from $16.47 to $7.06. The overall cost to the insurer (with mental health treatment factored in) was reduced by 31%.

- A study by Rosen and Wiens at the Medical Psychology Outpatient Clinic at the University of Oregon Health Science Center studied both children and adults (using a control group) and found significant group affects for changes in a number of medical outpatient visits, pharmaceutical prescriptions and diagnostic services. For each of these three measures - those receiving mental health services reduced their use of medical outpatient services by 41%.

- Group Health Association of Washington indicated that patients treated by mental health providers reduced their non-psychiatric physician usage within the HMO by 30.7% in the year after referral for mental health care compared to the previous year. Use of laboratory and X-ray services declined by 29.8%.

- Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment was on the order of $250 per year.

- In a study detailed at the April 1978 Southwestern Psychological meeting, it was found that among children, the presence of reimbursable mental health care reduced the mean number of physician visits for other purposes by 36%. Indeed, a matched control group for whom such mental health services were not made available, suffered an increase of 30% in the mean number of other physician visits during the same period.

- An unpublished study by Shapiro and Goldensohn (NIMH contract) using the Health Insurance Plan of New York (a comprehensive pre-paid group practice) compared a study group with three comparison groups regarding utilization of family doctors, specialists, x-ray, and laboratory services. The study group which received mental health treatment, showed a significant decline utilization of family doctor and specialist services compared with the comparison groups, and a decrease in x-ray and laboratory services.

Not only do we hope that this committee will look closely at the real financial costs in significantly reducing and possibly eliminating mental health, drug abuse, and alcohol programs, but we hope that the human costs will also be closely examined. This nation has been successful in sharply reducing the populations at state run mental institutions, and treating individuals in a humane fashion in their communities where they can be with the families and homes. It should be remembered that areas with community mental health centers have lower admission rates to state hospitals than areas without community mental health centers. Furthermore, community mental health centers have accounted for over half the growth in recent years in day care programs, and stimulated the growth of non-hospital based residential care where appropriate. From 1955-1977, the number of patients in expensive state and county mental hospitals was reduced from 550,000 to 160,000.

Our organization shares Congress' concern that fraud, abuse, and waste must be eliminated from federal programs. We are concerned, therefore, that by turning over $1.1 billion to states - with no strings or accountability attached-that we are opening up the door to potential mismanagement and abuse. Remember, the block grant proposal will turn over large sums of money to state governments regardless if they have the capacity to handle those sums properly.

The Federal financial investment in community mental health centers has proven to be a wise one. The federal seed money concept has served to generate a great deal of state and local support. Each federal dollar invested in the community mental health program has generated $3 of other funds. In years 1-2 of federal support, every federal dollar is matched, on the average, with 1-5 non-federal dollars. By year 7-8, every federal dollar is matched, on the average, with 4 non-federal dollars.

We strongly urge this Committee to appropriate funds under the authority of the recently enacted Mental Health Systems Act. The sections of this bill for which we are asking funding are as follows:

APPROPRIATION RECOMMENDATIONS

Section 107-Allotments to States to Improve the Administration of State Mental Health Programs:

This section authorizes funds to assist states in planning and program design, data analysis, research, enforcement and other administrative duties. These grants will help assure that patients will be referred to appropriate community agencies which provide mental health and supportive services upon hospital discharge. The National Council of Community Mental Health Centers recommends $7.5 million for FY 1982.

Section 201-Grants for Community Mental Health Centers

Under section 201, new and continuation grants are awarded to centers to meet their costs of operations. These grants are provided for up to eight years to help communities provide comprehensive mental health services to all in need in a defined geographic area. It is imperative that grants continue to be available to community mental health centers, since an estimated 3 million people currently depend on centers for mental health services. We recommend $227.5 million fo continuations and $25.0 for new starts. In addition, we recommend that the continuation and new start grants remain separate appropriations since they have separate authorization levels.

Section 202-Services for Chronically Mentally Ill Individuals

These grants provide funding for projects which focus on mental health and related support services for the chronically mentally ill. Our present mental health system suffers from what is commonly known as "dumping". Grants under this section will build on the Community Support Program. We will begin to establish a system which can help chronically mentally ill individuals to return and live in their communities with their families and avoid costly institutionalization. The National Council of Community Mental Health Centers recommendation - $45 million for FY 1982.

Section 203-Services for Severely Mentally Disturbed Children and Adolescents

At the present only 10 percent of the children and adolescents needing mental health services are receiving them. Children's needs are too often forgotten and their problems are exacerbated when effective programs are not available. By not treating recognized mental illness during a child's early years, we may forever lose.the chance for that individual to have a productive life. The National Council of Community Mental Health Centers recommendation - $10 million for FY 1982.

Section 204 (a) and (b)-Mental Health Services for Elderly Individuals and Priority Populations

At present, the elderly are one of the most underserved populations in the nation. There is an alarming extent of mental illness among the 65 and older population, while at the same time this group is underserved by public programs and by private mental health professionals. Only 2 percent of private psychiatrists' patients are over age 65, and only 4 percent of patients in community mental health centers are over 65. This section will also allow grants to be targeted to other underserved priority population groups. These groups, would be determined by the state. The National Council of Community Mental Health Centers recommendation - $30 million for FY 1982.

Section 205-Non-Revenue-Producing Services

These grants will provide graduate centers with federal support to meet the costs of consultation and education, follow-up, case management, and other non-revenue-producing services. In a sense, this grant category replaces consultation and education and financial distress grants which were authorized under prior legislation. The National Council of Community Mental Health Centers recommendation $30 million for FY 1982.

Section 206-Services for Mental Health in Health Care Centers (Linkage)

Linkage grants are declining eight-year grants available to service providers and ambulatory health care centers to assist health care centers in providing mental health service to the needy. As studies mentioned earlier indicate, the costs of health care are reduced when mental health care is available. The National Council of Community Mental Health Centers recommendation - $5 million for FY 1982.

Section 207-Grants and Contracts for Innovative Projects

These grants can include projects for the:

- training and retraining of employees adversely affected by the phasing down of state institutions,
- the innovative use of personnel in the management and delivery of mental health services, and
- any other innovative project of national significance respecting mental health services and mental health services personnel.

The National Council of Community Mental Health Centers recommendation - $1.0 million for FY 1982.

Section 208-Grants for the Prevention of Mental Health Illness and the Promotion of Mental Health

Priority targets for prevention programs are high risk groups, such as elderly widows, families mourning the death of a child or loss of spouse, teenage mothers, single parents and hospitalized children. Research data indicates that for these groups expenditures used in prevention programs can help to avoid serious mental or emotional illness later in life. The National Council of Community Mental Health Centers recommendation - $6.0 million for FY 1982.

Section 305-Applications and Provisions for Exclusive Agent States

Under the Act, a state mental health authority may become the exclusive agent for the state and for all entities within the state which receive grants under the Mental Health Systems Act. In order to qualify, the state must demonstrate that it has an effective community program for the mentally ill, and must meet various other federal requirements. This appropriation would assist those states which qualify to act as exclusive agents in meeting the costs of performing its functions. The National Council of Community Mental Health Centers recommendation-$1.0 million for FY 1982.

Section 317-Evaluation and Monitoring

It is essential that the quality of programs be examined. Evaluation and monitoring functions are important components of any program. The National Council of Community Mental Health Centers recommendation - $3.0 million in FY 1982 for Evaluation, $2.0 million in FY 1982 for Monitoring.

Section 326-Technical Assistance

This funding would be available to the Secretary, to provide technical assistance, including short-term training, to any recipient of a grant under title II. The National Council of Community Mental Health Centers recommendation - $5.0 million in FY 1982.

Section 502-Protection and Advocacy

Section 502, protection and advocacy programs, we recommend an appropriation of $3.5 million for FY 1982. These grants, which provide advocacy services, must be independent of service providers, and grantees must have ability to pursue a range of legal, administrative and other appropriate remedies. Patients which have complaints about their treatment will be able to be competently represented by individuals who have no conflict of interest.

Title VI-Rape Research and Services

Funding for rape research should be phased out and a program for services for rape victims and their families be fully implemented. Grants under section 602 could be used for counseling services as well as for assistance in obtaining social, medical, and legal services for rape victims. The National Council of Community Mental Health Centers recommendation - $ 5.0 million for section 602 in FY 1982.

In conclusion, we support the Administration's objective to eliminate wasteful programs and reduce unnecessary costs. This Congress has the responsibility to the taxpayers of this country that this be done. Congress, however, will be abdicating its responsibility if it doesen't examine each program carefully to determine if it's worthy of continued federal support. The Mental Health Systems Act was carefully examined by the Heritage Foundation which advised the Administration to gear up for its implementation of the Systems Act. We agree.

NCCMHC APPROPRIATION RECOMMENDATIONS

FY '81 -

1. Extension of the current Continuing Resolution thru September 30, 1981.
2. Oppose $38 million rescission for mental health services.
3. Oppose $80 million rescission for state alcohol and drug abuse formula grants.

FY '82 -

1. Appropriate adequate funding under the authority of the Mental Health Systems Act, P.L. 96-398:

Section 107 - State Administration	$7.5 million
Section 201 - New Starts	25.0 million
Section 201 - Continuations	227.5 million
Section 202 - Chronically Mentally Ill	45.0 million
Section 203 - Children	10.0 million
Section 204 - Elderly & Priority Populations	30.0 million
Section 205 - Non-Revenue-Producing Activities	30.0 million
Section 206 - Linkage	5.0 million
Section 207 - Innovative Projects	1.0 million
Section 208 - Prevention	6.0 million
Section 305 - Exclusive Agent	1.0 million
Section 317 - Evaluation & Monitoring	5.0 million
Section 326 - Technical Assistance	5.0 million
Section 502 - Advocacy	3.5 million
Section 601 - Rape Research	0
Section 602 - Rape Services	5.0 million
TOTAL	406.5 million

STATEMENT OF JEFF VAN SICKLE

OVERVIEW ON ADMINISTRATION BUDGET PROPOSALS

The National Mental Health Association's analysis of the Reagan administration's budget proposals, shows that the principle of reducing federal spending in social programs in an evenhanded manner has not been followed with respect to mental health issues. As is unfortunately so often the case, the mentally ill are being asked to shoulder an excessive burden as a result of these cuts: the research budget of the National Institute of Mental Health has not been treated comparably to the NIH budget; mental health training will be totally eliminated, while other health professions' training is only being reduced; cuts in Medicaid combined with the abandonment of the new Mental Health Systems Act could severely reduce community services, resulting in greater dependence on state mental institutions.

COST OF MENTAL ILLNESS

Mental illness now costs America over $30 billion each year; in part these costs result from failure to adequately fund research, and a distorted service system which unnecessarily places more people in institutions because of archaic funding mechanisms focusing on payments for institutional care and this fails to furnish early treatment to prevent more debilitating (and costly) illness. Both the private sector and all levels of the public sector share part of the blame for this, but overall, the federal role has been the most progressive and productive in helping to prevent mental illness and restoring the mentally ill to full functioning as quickly as is feasible. Currently, 15% of the population suffers from mental illness; the costs of direct treatment (public and private) run at %15.8 billion a year. The federal contribution to this expenditure is $350 million for the community mental health program. This relatively small federal investment has, however, served as a catalyst for change: for every $1 of federal community services funding, $3 are generated from other public and private sources. Mental Illness remains the number one cause of hospital admissions in this country, and accounts for more days of inpatient care than any other illness.

In addition, much of the cost of mental and emotional illness is hidden in general health care costs. In 1977 it was estimated that about 11% of the direct cost of all health care (or $17 billion) was in fact costs for mental disability. Indirect costs through loss of productivity, etc., are even greater. In direct contrast to these data, which indicate that mental illness is a substantial financial drain on American society, the federal government's spending on health care shows a consistent pattern of discrimination against the mentally ill in third party insurance programs together with a disproportionate small allocation of federal health dollars towards services and training programs related to mental health. For instance, less than 6% of federal health services dollars are allocated to the problems of mental health; only 4.3% of health research funding is allocated to the NIMH.

In terms of services, data clearly show that expenditures to assure adequate treatment of the mentally ill pay off both in terms of improved outcomes for patients and reductions in other inappropriate use of medical and health resources. A compilation of studies recently published by ADAMHA indicates that inappropriate utilization of other medical and health services is reduced so substantially that, even when the cost of appropriate mental health care is factored in, savings result. Cost savings have been determined through controlled studies which show an overall reduction of 31% in costs to Blue Cross when mental health services were made available to individuals who were high utilizers of other services. A 41% reduction in medical services utilization by patients of an Oregon outpatient clinic resulted when a mental health benefit was included, and there was a 30.7% reduction in similar utilization in Group Health Association in Washington, DC, when mental health services were available. Some dozen similar studies have replicated these results.

Thus, it is past time that federal health resources were allocated on the basis of need and the extent and cost of the illness to society. Yet, in direct contrast to this need, the Administration budget further exacerbates the problem by cutting proportionately more from the programs designed to help the mentally ill than from those designed to assist individuals with other health problems. How can this be identified?

MENTAL HEALTH SERVICES

The NMHA is appalled by the Administration's proposal to repeal the Mental Health Systems Act (MHSA)-- a law designed to return control and planning for mental health services to the states and to build a firm and real partnership between community entities, local, state, and federal governments, in designing a system of care which would ensure appropriate delivery of services to those most in need.

The MHSA grew out of many years of study and evaluation of legislation originally passed in 1963, which has always enjoyed broad bipartisan support. One of the major goals of MHSA is to address the need for coordinated delivery of care and services for the chronically mentally ill--one of the neediest and most dependent groups in society. Other provisions in the act would adjust the current community mental health centers program so as to place far more emphasis on groups now underserved, such as those living in rural areas where no mental health care services are available, the elderly, children, minorities, and others. Title V of the Act provides the accountability mechanism to insure that appropriate and adequate services are provided.

A 25% cutback in mental health services funding will not even permit the existing CMHC programs to be funded at expected levels--thereby ensuring that none of these new initiatives will even get off the ground. Worse yet, this cutback in federal community care services, coupled with the proposed cap on the Medicaid program, can be expected to have a severe impact on the availability of community care for the mentally ill. The very real possibility exists that we are going to see extensive reductions in community care, while institutional services must still be paid for. Even as the current community care movement has progressed over the last twenty years, state institution budgets have also increased despite the great reductions in the number of institutional patients. This clearly shows that state funding patterns foretell a retrenchment in community care if drastic federal cuts are made in mental health spending. This trend will be unintentionally strengthened because public and private third party payments emphasize institutional care, and because there remains a tremendous stigma on the mentally ill. Communities simply do not want the mentally ill living near them. Thus there will be economic, political, and public pressure to return patients to the institutions.

States and localities are clearly not in any condition, economically, to pick up the slack if the federal government's commitment is so suddenly and dramatically reduced. Yet, ironically, costs to society as a whole increase when institutional care is substituted for community care for the mentally ill. Costs accrue to the unemployment system, public assistance and welfare, criminal justice system, and general health care system.

The Administration proposal to consolidate all health services programs into a single block grant would make it very difficult to protect the mental health funding component (thus in fact we may see more than a 25% reduction in community services for the mentally ill as a result of this proposal). The block grant virtually guarantees that the principles and provisions written into the Mental Health Systems Act to ensure and encourage state-wide planning of a coordinated community and institutional care system,addressing especially the needs of the underserved and those unable to pay,will not be put into place. While the Administration hopes to cut administrative costs, we can be sure that such costs will rise at the state and local levels, even though federal costs may diminish. Since in the mental health area the federal government has always sought to shift treatment priorities and has never become involved in long-range funding of direct services (all programs funded receive only eight years start-up money), and since the MHSA was specifically designed to return a great deal of authority for decision to states and localities,it appears to NMHA inappropriate to include the mental health programs within the larger health services block grant. We oppose the repeal of the MHSA, and urge that it be funded, at least initially, in order to bring about the changes in the system which were designed by the last Congress, together with this Association, the State Mental Health Program Directors, and the National Council of Community Health Centers, with the support of most other major mental health organizations. As an illustration of the importance of the federal community program, applications for new awards continue to flow into the NIMH--as of September, 1980, there were a total of 128 such applications, totalling $40 million. As of March, 1981, this had increased to 142 applications requiring $52 million.

MENTAL HEALTH RESEARCH

The Administration proposes to reduce the expected FY 1981 mental health research budget from $146.3 million to $142.7 million and is proposing a FY 1982 level of $144 million. The National Mental Health Association (NMHA) determined that a level of $180 million would allow for an adjustment for inflation, and for a small increase in spending. Yet, by contrast, the total budget for the National Institutes of Health will receive an increase of over $200 million .

Of particular concern to the NMHA is the Administration's proposal that research on social factors related to mental health and mental illness, funded through certain extramural research programs, should be phased out entirely. It is not clear why the Administration has singled out social science research for targeting. What is clear is that the Administration is deviating from its promise to treat all programs comparably when making these cuts. Such categorical and inequitable cuts across branches and programs at NIMH are fiscally irresponsible in that they will force the cessation of certain types of mental health research which are of particular relevance to the consumer of mental health services, and countless individuals whose costly and debilitating mental problems might have been prevented.

One interpretation of the proposed targeted cuts is that the Administration, stating that federal funds should not be used for social change, presumes that social science research is "social change" research . This perspective does not recognize a crucial factor relevant to the understanding of mental illness: every individual who is mentally ill, or who might become mentally ill, lives in a social environment, and is affected by that environment. When discussing the breadth of mental health research, we refer to three primary types of research: biomedical research, behavioral science research and social science research. This three-pronged approach represents three inter-dependent and critically related elements of human health and illness. Every person has a physiology, every person behaves, thinks and feels, and every person lives in and reacts to a social environment. Mental illness and the capacity to remain mentally healthy is related to all three dimensions. To ignore any component of this picture is to mis-direct research efforts.

Before sweeping decisions are made to eliminate an entire category of research, we should look at what would be lost to society in both human and economic terms, if such research is not funded.

We have learned, for example, that social support systems and social networks, such as family, friends and community groups can be critical to the adjustment of severely disabled persons to society. Such support systems, independently, or together with formal therapies, can make the difference between a deinstitutionalized person's ability to re-adjust to society and whether or not that person will be re-institutionalized. Social supports also can play an important role in the prevention of mental and emotional disabilities, in that they can strengthen an individual's ability to withstand factors which otherwise might lead to such disabilities. If, through continued social science research, we can learn more about how to strengthen families and use social networks to assist in the treatment and prevention of mental illness, the savings in federal dollars will be great.

Families of aging persons provide 80% of the services needed by the elderly in the United States, yet the stress of caring for their aging relatives can stretch the capacity of family members to the limit. This is particularly true when the aging person has a mental disability. Research is just beginning to tell us how we can strengthen families so that they can continue to provide care to their aging relatives, and so that we can prevent the development of debilitating mental disabilities in family members. Obviously, it is both humane and cost-effective to learn how best to strengthen these families, so that they can continue to care for their aging relatives in the community.

We also know that social factors, such as the loss of social supports, can lead to serious physical health problems. Stress brought about by social factors can lead to significant chemical changes in the body, which can contribute to ulcers, cardiac problems, hypertension, cancer, degenerative diseases and so on. The link between physical and mental health and illness is a critical demonstration of the need for balance in federal funding in research, so that we can study all of the inter-dependent aspects of a person's functioning, including social, biomedical and behavioral.

Social science research also has led to the development of a successful model for group homes for delinquent and emotionally disturbed youths. This research utilized earlier findings in the area of social learning, and developed, refined and evaluated a program which has been demonstrated to be more cost-effective than institutionalization. The program is being adapted for use with developmentally disabled, and mentally retarded adults, autistic children and emotionally disturbed children. It has potential for use with other populations as well. Social science research also is helping us to learn more about the causes of violent behavior, and how criminal behavior develops. Such understanding is essential if we are to strive toward prevention and treatment. We are learning how to assist the police in coping with the tremendous stress and strain of their work, since research has indicated that they are more vulnerable to the development of physical and emotional problems due to these pressures.

Without research on social factors related to mental illness and mental health, we cannot develop effective strategies for prevention of mental and emotional disorders. We must study healthy and normal functioning throughout the individual's lifespan in order to learn how to prevent these disorders. We must look, simultaneously, at all aspects of healthy and disabled functioning, from the biochemical, behavioral and social perspectives.

In other research areas, critical gains have been made in the development of pharmacological and psychotherapeutic treatment strategies for depression, anxiety disorders and schizophrenia. Thousands of individuals are now able to function effectively outside of institutions, and thousands of others are learning through behavioral and other psychotherapies how to cope with internal stress and how to head off the development of serious mental or physical disability.

We feel that the priority areas deserving continued and consistent funding have been appropriately addressed in the ADAMHA Five Year Plan. The unanswered questions about mental and emotional disorders are many, and any cuts in the NIMH research budget can only increase the costs to society through drains on the health care system and loss of productive members of the workforce. We emphasize again the need for a balanced and multi-dimensional approach to the funding of mental health research.

RESEARCH TRAINING

The proposed reductions in research training funds (from an appropriated level of $19.5 million for FY 1981 to $13.4 million in FY 1981, and $11.8 million in FY 1982), will seriously affect our ability to conduct the crucially necessary research into the causes and treatment of mental illness in the years ahead. Indications are that the Administration would like training for researchers in the social sciences to take the brunt of these cuts, so that such research training would be phased out eventually. We are as concerned about the phasing out of funds to train specific types of mental health researchers as we are about the targeting of specific types of mental health research. We oppose such cuts.

The NMHA had recommended that the current research training funds for FY 1981 of $19.5 million be increased to $30.0 million for FY 1982. The reasons for the need for this increase are many. First, mental health researchers and academicians earn significantly less income than their colleagues of the same disciplines in other careers, as was demonstrated by a survey conducted by the General Accounting Office in 1979. Because of this great salary differential, talented and bright potential researchers must be attracted to research careers. Second, since their incomes are relatively low, it is extremely difficult for these individuals to pay costly tuition and living expenses throughout their training years. The GAO survey also indicated that individuals supported by federal research funds actually do enter and remain in research and teaching careers and do "pay back" their nation through years of research service.

Unless talented personnel are attracted to research careers early in their training, the likelihood is high they will never become involved in research. Without federal funds to assure the training of a new generation of researchers, there will not be individuals to carry on the critical activities needed to increase our knowledge about mental health and mental illness.

Finally, it is important that federal research training funds be administered to trainees in a manner which is consistent with the training model of their discipline. That is, there has been a recent trend toward awarding primarily post-doctoral research training fellowships. This policy is insensitive to the fact that many of the core disciplines which provide the sources of talented research personnel emphasize research training at the pre-doctoral level. Therefore, we encourage NIMH to employ greater flexibility in the allocation of pre-doctoral versus post-doctoral fellowships. If NIMH continues to move toward the funding of post-doctoral fellowships exclusively, the NIMH research training funds will "cut out" certain core disciplines, such as psychology, which are essential to research manpower.

CLINICAL TRAINING

The Administration budget proposes a three year phase out of the NIMH clinical training programs, while other health training funds would be direct toward meeting identified needs in shortage areas and for certain medical specialities.

NMHA believes that in the mental health training arena there are adjustments which should be made in federal public policy. We strongly support the provision in the MHSA which requires students who benefit from federal training funds pay back such training by service in underserved areas or in public or nonprofit programs initiated under the CMHC or MHSActs. We also strongly support efforts to improve the training of individuals to serve underserved populations, particularly, the elderly, children, the chronically mentally ill and minorities. Historically, mental health professions have not adequately served these population groups, and specific training in some of these areas is new and is not widely available.

In view of the above, and of the scarce federal dollars. The NMHA recommends federal mental health manpower funds be used specifically for: a) stipends with payback requirements defined to ensure that these professionals provide service to the many underserved individuals in this nation who cannot find or cannot afford mental health treatment when they need it; and b) for training through the current NIMH special centers for aging, children, chronically mentally ill, crime and delinquency and minorities.

Thus, in the area of clinical training, NMHA supports a re-evaluation of the direction of federal funds. We are, however, opposed to a complete and arbitrary elimination of this item given the desperate shortage of trained mental health specialists to work in state institutions, other public and nonprofit community programs, rural and inner city areas, and with special population groups historically disadvantaged with respect to mental health care. Once again, we believe the current Administration's approach is too general and sweeping, and is merely throwing out "the baby with the bathwater".

In addition to the above comments on the ADAMHA budget, NMHA also would like to go on record opposing some other Administration proposals for cuts which will seriously hurt the mentally ill, particularly the poor.

MEDICAID

The concept of an arbitrary cap on Medicaid is totally against the stated objectives of the Administration to ensure that those most in need will not suffer through this readjustment of federal priorities. Medicaid serves only those most in need, and a cap on federal spending cannot be expected to result in significant increases in state spending for these services, instead cuts in services to low income individuals must result. Our past experience, and the widespread stigma against mentally ill individuals and mental health treatment, leads us to conclude that once again the low income individual with mental illness will be one of the first to suffer. Most of the mentally ill served under Title XIX are either elderly or under 21--two of the most underserved population groups in our society as a whole with respect to mental health care. Why should we ask these individuals already disadvantaged because of their poverty and their illness to bear the burden of these cuts? NMHA believes that Medicaid reforms should be proposed and that significant savings may be feasible within the program, but that an arbitrary cap on services only hurts most those most in need, but least able to defend their rights.

EDUCATION FOR ALL HANDICAPPED CHILDREN

Emotionally disturbed/mentally ill children have been one of the most underserved populations in educational programs. The passage of PL 94-142, Education for All Handicapped Children, made them eligible in all states for free and appropriate education. Progress has been made in obtaining collaborative agreements between the Departments of Education and Health and Human Services to assure children with emotional problems are appropriately served. The proposed 25% cutback in funding for education programs and the placement of Education for All Handicapped Children in a block grant will be a major setback. There would no legal, targeted authority to assure these children will receive a "free and appropriate education".

Many of these children are poor and have no private resources to turn to for services. Without the protection and leadership of PL 94-142 as well as the major reduction in funding, many disadvantaged children, who could become productive and tax-paying adults, will become a drain on society because there will be fewer compensatory special education resources.

CONCLUSION

The NMHA recommendations for FY 1982 funding are shown on the attached table. While we fully recognize the need for fiscal constraints and reduction in overall federal expenditure, we vehemently oppose efforts to balance the budget on the backs of the mentally ill.

Research: The need for a federal role in health research is undisputed. NMHA urges that the Congress when appropriating funds for research treat the NIMH budget equitably with respect to other health funding, and particularly urges that we continue the current balanced approach to research.

Services: The Mental Health Systems Act is philosophically akin to a block grant for mental health services. It was carefully crafted and overwhelmingly passed by the 96th Congress as a decentralized program based on a creative partnership between all levels of government, a concept endorsed by the Reagan-Bush campaign in a letter to NMHA last fall. The Systems Act targets specific services for the most underserved populations, particularly the chronically mentally ill whose status in America is now accurately portrayed as a national scandal. The Act should be kept intact and given a chance to work.

Training: MH training should be substantially restructured, but continued federal funding for stipends to students in all disciplines is essential, with such students paying back this support through service in underserved areas, state institutions or programs funded through the CMHC or MHS Act. Training of specialists to treat the most underserved populations should also be continued.

Other programs: NMHA strongly opposes dissolution of the Education for All Handicapped Children program, the arbitrary cap on Medicaid funding and is concerned about the extent of cuts in many of the other programs that the mentally ill must rely on: Title XX, housing, other education programs, and rehabilitation.

REAGAN ADMINISTRATION BUDGET REVISIONS FOR NATIONAL INSTITUTES OF MENTAL HEALTH

	FISCAL YEAR 1981		FISCAL YEAR 1982		
	Current	Reagan	Carter	NMHA	Reagan
RESEARCH					
Extramural	113.3	103.8	134.2	138.1	102.8
Intramural	38.8	38.9	41.9	41.9	41.8
TOTAL	152.1	142.7	177.1	180.0	144.6
SERVICES					
A. Community Programs:					
Continuation of CMHA	259.0		241.3	252.5	
New CMHCs	24.9		16.0	30.0	
Elderly Programs	n/a		(	9.0	
Priority Pop. Programs	n/a		13.0 (	6.0	
Linkage grants	1.5		5.0	5.0	
Prevention	1.5		5.0	6.0	
Non-revenue Prod Services to CMHCs	8.7		9.0	20.0	
Advocacy Programs	n/a		0.0	5.0	
Financial Distress	12.0		n/a	n/a	
B. State Programs:					
Chron. MI	15.0		37.8	39.0	
MIN Children	1.5		6.0	10.0	
State Admin.	0.5		5.0	5.0	
Exclusive Contracts with States	n/a		1.0	1.0	
C. Rape	0.0		0.0	1.0	
TOTAL	324.3	285.7*	339.1	389.5	
TRAINING					
Research Training	19.5	13.4	20.0	30.0	11.8
Clinical Training	74.4	59.6	73.1	----	47.3
TOTAL	93.8	72.9	93.1		59.1

*Continuations only

STATEMENT OF RICHARD PRUSS

Mr. Chairman, members of this prestigious body, I am grateful for this opportunity to testify.

My name is Richard M. Pruss, and I am President of Therapeutic Communities of America, a consortium representing more than 600 not-for-profit drug free treatment agencies, from coast to coast, which are effectively treating people who were once addicted to drugs: legal and illegal drugs, costly and cheap drugs, all of them damaging when misused and some of them brutally deadly.

I am also Executive Director of Samaritan Halfway Society, a multi-modality drug abuse prevention and treatment agency in New York. I can, therefore, offer the committee special perspectives on our work both nationally and at the community level and I appreciate your invitation to share information with you.

Last year Therapeutic Communities of America brought petitions with a quarter of a million signatures to this subcommittee hearing in boxes carried by some of the young people we treat. Today many of those youngsters are back with their families in school or working.

We are direct providers of treatment services appealing to this committee as a voice from the front lines, from the drug abuse trenches, and my statement will address those two categories of funding which affect us directly. The National Institute on Drug Abuse budget identifies them as Grants to States Formula 409 and Community Project Grant 410 funds.

Those two categories represent the funds that provide treatment for addicts and substance abusers. They are utilized by states, municipalities and private, not-for-profit programs. I am here today on behalf of those private non-profit corporations.

The Republican platform on drug abuse stated: "Private, non-profit drug abuse rehabilitation agencies have taken the lead in fighting drug abuse, and they deserve greater cooperation and flexibility from federal, state and local agencies and grant programs".

The rescission proposed in FY 81 in 409 and 410 funds reduces funding for those programs by 31 million dollars, and represents both a 16% funding cut and elimination of 409 funds entirely.

After being proposed for total elimination in the former Administration's FY 81 budget revisions submitted last March, the House Committee on Appropriations restored the Formula 409 program to the ADAMHA budget with the following language: "The Committee is willing to support a policy which suggests that the state should pick up a larger share of the cost of supporting state-run treatment programs. It could not, however, accept the total elimination of these grants on such short notice as proposed in the March (1980) revision to the budget. This would have done irreparable damage to a program of absolutely essential services...it is clear that many persons would lose services in such an abrupt transition." The House Committee's decision to restore the formula grant program was reinforced when the recommended appropriation of $30 million for the drug formula grant was included by both Houses of Congress in two subsequent continuing resolutions. Obviously, the impact will be even greater at this time, as we are even further into the 1981 fiscal year.

We have heard much about increases in appropriations in recent years for Health and Social Service Programs and have been told that we all must take cuts of equal magnitude. In the area of drug abuse, however, treatment and prevention funding, have already suffered these cuts.

Combined Formula 409 & 410 Appropriations:

- in FY 79 was	201 million
- in FY 80 was	199 million
- in FY 81 (prior to recision)	191 million
- in FY 81 if recision is adopted	161 million

The $10 million dollar cut from FY 79 to FY 81 represents a 5% cut. If the recision is approved then the total cut sustained by drug abuse funding will have been $40 million or 20%.

These reductions come prior to us facing the consolidated block grant across the board cut of 25%.

At his press conference on March 6, 1981, President Reagan made the following statement:

"Q. Mr. President, in light of what appears to be a growing concern about the drug abuse problems, especially among teenagers, what will your priorities be and specifically, do you expect to have a White House policy on drug abuse?"

"A. Yes, I do, and in fact it can be stated as clearly as this: I think this is one of the gravest problems facing us internally in the United States.

"I've had people talk to me about increased efforts to head off the export into the United States of drugs from neighboring nations. With borders like ours, that as the main method of halting the drug problem in America is virtually impossible; it's like carrying water in a sieve.

"It is my belief -- firm belief -- that the answer to the drug problem comes through winning over the users to the point that we take the customers away from the drugs, not take the drugs necessarily--

try that, of course you don't let up on that. But it's far more effective if you take the customers away than if you try to take the drugs away from those who want to be customers.

"And I envision, whatever we can do at the national level, to try and launch a campaign nationwide. Because I think we're running the risk of losing a great part of a whole generation if we don't."

Our national campaign against drug abuse will be drastically undermined, first by the proposed FY 81 rescission of $30 million in formula 409 funds, by the $755,000 cut in 410 funds, and further by the FY 82 25% proposed cut within the Health Services block grant. The combined impact of these cuts means drug abuse funding will have sustained a 45% cut from FY 79 to FY 82. This comes at a time when programs across the country are operating at or above 100% capacity.

Using Therapeutic Communities as an example, I would like to discuss briefly the false economy of reducing treatment funding. The courts utilize residential drug free treatment as an alternative to incarceration. Not only is treatment far more productive in rehabilitating our youth but is far less expensive than incarceration.

A survey of a sample group of National Institute on Drug Abuse funded therapeutic communities indicates that approximately one out of every three clients is mandated into a treatment program as an alternative to prison. Of 13,530 clients 4,510 are in treatment as a court mandated alternative to incarceration. Therapeutic Communities are funded at a total of $6,010 per slot, per year for 24 hour residential treatment. Of that amount, the federal government contributes only $3,606 with the balance being provided by other than federal funding. The total cost per year for 4,510 clients is $27,105,000. If imprisoned at $20,000 per year, the same number of individuals would cost the tax-payer $90,200,000. Treatment saves more than lives -- it saves tax dollars.

The information just cited doesn't take into account the cost of crime, loss of productivity in the marketplace or the fact that therapeutic communities break individuals out of the welfare dependency cycle, creating tax-paying, productive members of society. One of our member agencies discovered that the annual personal income taxes paid by its graduates now exceeds the annual grants received from government.

Let us not ignore the appalling crime rate that is so closely related to drug abuse in America. A careful analysis reported last fall, by several Temple University researchers found that over a period of 11 years, 243 male addicts committed more than 500,000 crimes. It also found that when these same addicts were off drugs, their crime rate plunged 84%. "A major means for reducing the amount of addict crime," the study found, "is to reduce their drug use."

Furthermore, surveys indicate that the American family considers drug abuse one of the major threats to the survival of family life and to the very structure of the family unit as we know it. Drug abuse ranks high on the list of problems permeating society at all socio-economic levels.

Based upon the following information, the American family has much to be concerned with.

- According to the Drug Enforcement Agency, twenty times the amount of opium is being grown and exported at this time then there was in the late 60's and early 70's, when the United States experienced a heroin epidemic. The countries of origin are Iran, Afghanistan and Pakistan, with no cooperation forthcoming to slow the traffic at its source.

- 40.5% of all drug-free therapeutic community clients are of military age (18-24) and compose the primary age group addicted to heroin. The problem of addiction within the armed forces is wide-spread, and undermines our military readiness.

- Poly-drug abuse permeates all socio-economic stratas of our society, nurtured by permissiveness towards illicit drugs and easy access to pharmaceutical drugs which are diverted or available in home medicine chests. Although abused by all age groups, adolescents are most often the users. 23% of all therapeutic community residents are under age 19.

The proposed placement of drug abuse into a block grant with fourteen health providers will have a devastating impact on a national war on drugs which must continue. State militias are not called upon by Washington to provide our national defense, neither can the states do more than participate in a partnership with the federal government in our nation's war on drugs.

Although we have a large national constituency, we have to contend, every day, with the prejudice, the suspicion and, in some cases, the hostility that drug-treatment programs are still obliged to face especially on the community, county and state level. There are grave ironies involved here. At a time when the nation is being flooded with heroin, in volumes 20 times greater than the deadly "French Connection" tide of the 60's, shame, embarrassment and neighborhood resistance to drug-treatment services continue. Elected officials are aware of this. And there is, therefore, a real risk that essential funding for our programs may be affected unless the federal government sets a steadfast example of support.

There is a continuing need for partnership between federal officials in Washington and the nation's providers of private, not-for-profit treatment. We cannot hope to maintain that partnership without the help of the congress. That's why we are here today.

In conclusion, I would like to quote Senator Orrin G. Hatch, speaking before the National Alcohol & Drug Coalition Conference in Washington, D.C., September 1980:

"Government must support social service programs which are geared to foster independence. Government must not accept drug abuse but rather reaffirm our faith in the strength and potential of our youth to lead full and productive lives, drug-free.

It is time that Washington exerts moral leadership and sound the bugle in the war for a drug-free society."

We could not agree more with Senator Hatch. We have the experience, the skill and the motivation to help thousands, with your commitment and assistance, we will.

Thank you.

SUMMARY OF RECOMMENDATIONS

FISCAL YEAR 1981

"State Formula Grants" Section 409): Restoration of the $30 million currently proposed for rescission.

"Community Programs" (Section 410): Restoration of the $755,000 currently proposed for rescission. Increase of $3.5 million earmarked by the former administration for heroin impacted cities.

RECOMMENDED APPROPRIATIONS FY 81

(in millions of dollars)

State Formula Grants (Section 409)	$ 30
Community Programs (Section 410)	$164.5

FISCAL YEAR 1982

"State Formula Grants" (Section 409): Continuation of categorical funding within National Institute on Drug Abuse budget; increase of 6% for inflation.

"Community Programs (Section 410): Continuation of categorical funding within National Institute on Drug Abuse budget; increase of 6% for inflation. Increase of $1.5 million earmarked for heroin impacted cities.

RECOMMENDED APPROPRIATIONS FY 82

(in millions of dollars)

State Formula Grants (Section 409)	$ 31.8
Community Programs (Section 410)	$174.37

STATEMENT OF DIANA WILLIAMS

Thank you for the opportunity to present testimony on Federal appropriations for alcoholism programs on behalf of the National Council on Alcoholism.

NCA is a private, voluntary organization, comprised of 230 local councils on alcoholism and a national board of directors made of individuals of prominence in business, medicine, science and community leaders. NCA involves thousands of volunteers throughout the country who dedicate their time and talent to combatting the disease of alcoholism and preventing its harmful effects in the community.

This statement addresses two issues facing this Subcommittee: the request for rescission of funds already appropriated for FY 1981, and the Administration's proposals for FY 1982. I want to point out that while the Federal alcoholism programs are unauthorized for FY 1982, both Houses are progressing rapidly toward reauthorization. A bill has been introduced in the House of Representatives, H.R. 2272, to reauthorize the National Institute on Alcohol Abuse and Alcoholism for three years with a contingent extension in 1985, and a full day of hearings have been completed. A bill will soon be introduced in the Senate which will call for a one-year extension of research and demonstration activities of NIAAA. Hearings have been scheduled in the Senate for March 25th, 1981. Thus it can be anticipated that reauthorization will be complete in time to allow the Subcommittee to consider appropriations for FY 1982.

I. Rescission of Funds Already Appropriated for FY 1981

The President has requested the rescission of $53,176,000 of funds already appropriated for Federal alcoholism programs in FY 1981. These include:

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
Reagan Revised 1981

Research	-$ 540,000
Training	- 374,000
Community Projects	- 2,262,000
State Formula Grants	- 50,000,000
	$53,176,000

The National Council on Alcoholism strongly urges the Subcommittee not to act on the President's request for rescission of funds in FY 1981. These funds, in fact, have been appropriated twice by this Congress, included in two continuing resolutions for fiscal year 1981. Only the rescission requests and now a deferral order have kept them from the hands of those programs who rely on them. In making this appropriation, the Congress made a commitment that this money will be available to support ongoing programs and research this year. For nearly six months the programs have been living on borrowed money and borrowed time. It is critical that the Congress keep this commitment, and make the funds already appropriated for FY 1981 available to the people and the community. Not only honor, but also lives are at stake.

The Federal formula grant program supports nearly 1,200 public service programs. When these services are eliminated, nearly 1.5

million persons now receiving direct services will be without publically supported alcoholism programs.

The rescission of $50 million in state formula funds will result in the closing of these programs and immediately deprive people of treatment. Efforts are underway in many states to obtain funding from their own legislatures to replace formula funds, which have not been requested in the President's budget for FY 1982. But Congress made commitment for these funds in 1981, and that the commitment should be kept.

Moreover, many State legislatures have adjourned at this time making it possible for them to replace these funds. By the time the action is completed on appropriations for the remainder of FY 1981, many more will have adjourned. Those still in session will be far beyond the point of being able to revise their State budgets to make up for these funds. Included for the record is a listing of the alcohol formula funds by State and the impact of the rescission on each state.

The rescission request for research programs reflects the new Administration's policy to phase out social research. The revised request of $21,711,000 excludes funds for 5 new and 2 competing projects addressing the social aspects of alcohol abuse and alcoholism. The National Council on Alcoholism strongly urges this Subcommittee to appropriate these funds, and take a stand against the moratorium on social research. If this policy is carried out, some of the most critical research issues, including prevention, will be excluded from the National Research Program.

The National Council on Alcoholism calls on this Subcommittee not to act on the President's rescission request, and to make funds available to alcoholism research programs as approved by the Congress in PL96-537:

Research	$ 22,251,000
Training	5,821,000
Community Projects	73,000,000
State Grants	50,000,000
Program Support	10,167,000
Total	$161,239,000

II. Requests for Appropriations in Fiscal Year 1982

The President's budget for fiscal year 1982 requests a total of $37,925,000 for alcoholism programs administered by the National Institute on Alcohol Abuse and Alcoholism. This represents an overall decrease in the program administered by the Institute of 77% from the level of funding approved for FY 1981. This devastating reduction in program capability is evidence that the alcoholism program, whose job it is to combat the third leading cause of death and illness in this country, is taking a disproportionate share of the budget cuts in FY 1981. The amounts requested for 1982 are as follows:

National Institute on Alcohol Abuse and Alcoholism
Reagan Request for 1982

Research	$24,802,000
Training	4,533,000
Project Grants	-0-
State Formula Grants	-0-
Program Support	8,590,000
Total	$37,925,000

A small increase in research activities is provided to support the establishment of a new Alcohol Clinical Research Program at the National Institute of Health, and to provide for continuation of the National Alcohol Research Centers. The training request reflects the need for continuation of research training programs only, and is slated to be eliminated in its entirety by 1983. No funds are requested for community project grants and formula grants, which are slated for inclusion in the Administration's consolidated health services grant.

The National Council on Alcoholism proposes the following alternative to the President's request for alcoholism programs in FY 1982:

Research	$ 33,376,000
Training	5,821,000
Demonstrations	20,000,000
State Grants	92,250,000
Total	$151,447,000

A specific amount for program support is ommitted at this time. This will be developed according to the positions necessary to administer the revised program.

In the area of alcoholism research, NCA applauds the small increase provided for establishment of the Alcoholism Clinical Research Program and continuation of the National Alcoholism Research Centers, for these are needed elements of the research program. However, the $24.8 million requested is insufficient to boost the research program to a level which even approaches what is needed to meet the needs of this problem.

A copy of a recent report of the National Academy of Sciences Institute of Medicine is submitted to the Subcommittee as part of the official hearing record.

This report, produced after an extensive review of alcoholism programs by prominent scientists, concluded that support of alcoholism research is "disproportionately low relative to the estimated economic impact--about one-tenth of the amounts spent on heart disease or respiratory disease, and one one-hundredth the amount spent on cancer research, relative to the economic impact of these disorders." The report concluded that a greater portion of the resources within NIAAA be allocated to research, and specifically, appropriations should be increased by 50 percent in each of the next three years.

The National Council on Alcoholism strongly agrees with the Institute of Medicine's recommendations on alcoholism research, and therefore suggests that the appropriation be increased in FY 1982 to $33,376,000.

The National Council on Alcoholism also supports the Administration's efforts to shift the administrative and management responsibilities of treatment services to State and local governments. However, a consolidated block grant mechanism such as that under consideration is an insufficient means of assuring accountability for the use of public alcoholism service dollars. NCA will suggest to the authorizing committees as an alternative a targetted grant for alcoholism services, to be administered by NIAAA, and distributed directly to the States on the basis of population. Thus, NCA's appropriations request for FY 1982 for State grants in the amount of $92,250,000, represents 75% of project grant and formula grant funds appropriated in 1981. It is critical to our nation's economic goals to save dollars whenever possible, and this can be accomplished by reducing some administrative burdens of the existing grant programs. But it cannot be done capriciously, and should not be done without maintaining some level of accountability of the States beyond a simple annual audit.

Furthermore, the targetted grant to States should not be an ongoing Federal subsidy of treatment, but rather a program development mechanism. In order to get the most for the Federal dollar, NCA will advocate with the authorizing committees that Federal grant moneys be matched dollar for dollar by the States. This will provide a necessary incentive to State and local financing of programs, to go along with their management responsibilities.

Both House and Senate proposals to reauthorize NIAAA in 1982 contain authority for a small demonstration grant program to be administered directly at the Federal level. NCA strongly urges this Subcommittee to allot $20 million for this purpose in 1982 if the program is approved by Congress. This program will retain a very valuable knowledge development and information sharing tool at the Federal level, and will allow new knowledge to be developed in prevention and treatment services.

Thank you for the opportunity to present this information to the Subcommittee.

FEDERAL APPROPRIATIONS FOR ALCOHOLISM PROGRAMS (NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM)

	Current 1981	Reagan Revised 1981	Change from Current 1981	Reagan 1982	Change from Current 1981
RESEARCH	$ 22,251,000	$ 21,711,000	-$ 540,000	$24,802,000	+$ 2,551,000
TRAINING	5,821,000	5,447,000	- 374,000	4,533,000	- 1,288,000
PROJECT GRANTS	73,000,000	70,738,000	- 2,262,000	-0-	- 73,000,000
STATE FORMULA GRANTS	50,000,000[1]	-0-	- 50,000,000	-0-	- 50,000,000
PROGRAM SUPPORT	10,167,000	10,520,000	-0-	8,590,000	- 1,577,000
TOTAL	$161,239,000	$108,416,000	-$52,823,000	$37,925,000	-$123,314,000

Contribution to Consolidated Block Grant= 75% of Revised 81 Project Grants	$53,054,000
75% of Revised 81 Formula Grants	-0-
Total	$53,054,000

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[1] Funds have been appropriated in a continuing resolution, PL96-536, but never released to the states. Formula funds are new subject to an administrative deferral order, preventing their release, and to a 45-day waiting period while Congress considers the Reagan rescission request.

ALCOHOL FORMULA GRANTS

	1981 Presently Available	Revised Estimate	Proposed Rescission
Alabama..................	$974,210	---	-$974,210
Alaska...................	199,175	---	-199,175
Arizona..................	508,142	---	-508,142
Arkansas.................	567,973	---	-567,973
California...............	4,417,411	---	-4,417,411
Colorado.................	562,793	---	-562,793
Connecticut..............	623,808	---	-623,808
Delaware.................	199,175	---	-199,175
District of Columbia.....	199,175	---	-199,175
Florida..................	1,861,164	---	-1,861,164
Georgia..................	1,214,371	---	-1,214,371
Hawaii...................	199,175	---	-199,175
Idaho....................	203,119	---	-203,119
Illinois.................	2,309,327	---	-2,309,327
Indiana..................	1,227,442	---	-1,227,442
Iowa.....................	655,771	---	-655,771
Kansas...................	509,326	---	-509,326
Kentucky.................	886,067	---	-886,067
Louisiana................	1,006,517	---	-1,006,517
Maine....................	273,702	---	-273,702
Maryland.................	871,713	---	-871,713
Massachusetts............	1,261,230	---	-1,261,230
Michigan.................	1,945,114	---	-1,945,114
Minnesota................	897,609	---	-897,609
Mississippi..............	677,867	---	-677,867
Missouri.................	1,113,502	---	-1,113,502
Montana..................	199,175	---	-199,175
Nebraska.................	350,254	---	-350,254
Nevada...................	199,175	---	-199,175
New Hampshire............	199,175	---	-199,175
New Jersey...............	1,493,005	---	-1,493,005
New Mexico...............	303,494	---	-303,494
New York.................	3,727,457	---	-3,727,457
North Carolina...........	1,361,506	---	-1,361,506
North Dakota.............	199,175	---	-199,175
Ohio.....................	2,416,164	---	-2,416,164
Oklahoma.................	683,096	---	-683,096
Oregon...................	528,463	---	-528,463
Pennsylvania.............	2,682,713	---	-2,682,713
Rhode Island.............	214,167	---	-214,167

	1981 Presently Available	Revised Estimate	Proposed Rescission
South Carolina..........	756,146	---	-756,146
South Dakota............	199,175	---	-199,175
Tennessee...............	1,077,200	---	-1,077,200
Texas...................	2,924,897	---	-2,924,897
Utah....................	304,530	---	-304,530
Vermont.................	199,175	---	-199,175
Virginia................	1,138,214	---	-1,138,214
Washington..............	778,342	---	-778,342
West Virginia...........	475,785	---	-475,785
Wisconsin...............	1,072,514	---	-1,072,514
Wyoming.................	199,175	---	-199,175
American Samoa..........	8,089	---	-8,089
Guam....................	28,953	---	-28,953
Northern Mariana Islands.	3,466	---	-3,466
Puerto Rico.............	860,862	---	-860,862
Trust Territory.........	27,707	---	-27,707
Virgin Islands..........	23,873	---	-23,873
Total...............	50,000,000	---	-50,000,000

STATISTICAL WORK SHEET | NDSL-FCC: Tent. 81-82 & Final 80-81 Allocations | 3/9/81

	Tent. 81-82	Final 80-81	
TOTALS ⇨	$174,572,832	$284,781,511	61.30%
ALABAMA	3,032,149	4,411,225	68.74
ALASKA	106,395	272,457	39.05
ARIZONA	2,471,408	3,995,468	61.86
ARKANSAS	1,457,592	2,315,598	62.95
CALIFORNIA	18,645,715	30,446,730	61.24
COLORADO	2,630,961	4,082,828	64.44
CONNECTICUT	2,188,563	3,723,400	58.78
DELAWARE	476,005	694,520	68.54
DISTRICT OF COLUMBIA	1,267,348	2,142,562	59.15
FLORIDA	5,352,334	7,750,923	69.05
GEORGIA	3,351,786	4,771,040	70.25
HAWAII	704,278	962,102	73.20
IDAHO	691,801	1,156,062	59.84
ILLINOIS	8,202,893	13,963,298	58.75
INDIANA	4,034,327	7,344,307	54.93
IOWA	2,654,513	4,970,385	53.41
KANSAS	1,898,675	2,516,764	75.44
KENTUCKY	2,298,307	3,360,896	68.38
LOUISIANA	2,934,258	4,753,250	61.73
MAINE	736,958	2,687,936	27.42
MARYLAND	2,694,611	4,376,649	61.57
MASSACHUSETTS	6,413,797	12,688,241	50.55
MICHIGAN	7,034,675	9,819,165	71.64
MINNESOTA	4,024,214	6,196,582	64.94
MISSISSIPPI	1,857,664	2,765,908	67.16
MISSOURI	3,666,802	6,547,774	56.00
MONTANA	643,581	873,145	73.71
NEBRASKA	1,486,254	2,663,155	55.81
NEVADA	300,440	446,179	67.34
NEW HAMPSHIRE	778,588	2,224,499	35.00
NEW JERSEY	3,873,173	6,157,535	62.90
NEW MEXICO	956,144	1,727,480	55.35
NEW YORK	15,363,808	26,538,896	57.89
NORTH CAROLINA	4,424,314	6,681,355	66.22
NORTH DAKOTA	687,086	1,079,059	63.67
OHIO	7,541,896	13,316,914	56.63
OKLAHOMA	2,561,735	4,257,498	60.17
OREGON	2,204,750	5,209,019	42.33
PENNSYLVANIA	8,654,785	14,129,650	61.25
RHODE ISLAND	996,648	1,557,985	63.97
SOUTH CAROLINA	1,947,623	3,116,824	62.49
SOUTH DAKOTA	688,901	1,295,444	53.18
TENNESSEE	3,333,922	4,774,390	69.83
TEXAS	9,583,254	12,333,291	77.70
UTAH	1,612,401	2,020,580	79.80
VERMONT	542,383	1,675,375	32.37
VIRGINIA	3,601,047	5,223,079	68.94
WASHINGTON	3,840,324	5,904,420	65.04
WEST VIRGINIA	1,350,499	2,361,218	57.20
WISCONSIN	4,215,509	7,159,090	58.88
WYOMING	259,005	311,367	83.18
SERVICE SCHOOLS			
AMERICAN SAMOA			
CANAL ZONE			
Misc. Pac.	---	---	
PUERTO RICO	2,235,392	3,009,403	75.94
TRUST TERRITORY	---	---	
VIRGIN ISLANDS	11,341	18,591	61.00

Analysis Section,CBB
DPPD/OSFA/OPE/DE
3/9/81

REPLACES OE FORM 2404 (REV. 4-66) WHICH IS OBSOLETE

Statement of Margaret T. Gordon, Ph. D.

I am the director of the Center for Urban Affairs and Policy Research at Northwestern University in Evanston, Illinois. I am also chairing the National Advisory Committee to the U.S. Secretary of Health and Human Services on the Prevention and Control of Rape.

I am here to argue three basic points: 1) that rape is a heinous crime against all society; it affects not only the victim but you, your wives, mothers, daughters, sisters and friends as well; we must support those people and places where victims can turn for the kinds of help they need; 2) that if we are to maintain what advances there have been to date in the prevention and control of rape, it is appropriate for federally-supported services to be conceptualized to include technical assistance, outreach and education for communities; and 3) that social science research _is_ producing knowledge needed to plan more effective services for victims, and more effective educational programs for prevention and control. Now is exactly the _wrong_ time to withdraw support from these research efforts, and to do so could cause previous efforts to be wasted.

Now let me support these three points.

1) Rape affects all of us,

-- Next to murder, rape is the most feared crime;

-- Women are substantially more fearful than men, though they are the least victimized of every crime except rape;

-- 75% of women in the United States are afraid to walk alone on the streets in their own neighborhoods at night, and they are regarded as "asking for trouble" if they do so;

-- Rape, and the fear it induces in every woman (and in many men for their wives, sisters and friends), is destructive of individual lives (because women voluntarily barricade themselves indoors) and destructive of communities (because the participation of isolated, fear-paralyzed citizens is lost);

-- The victimization surveys conducted through the U.S. Census reported that 192,000 women were raped in 1979 (an increase of 47,000 or 24% over the 1976 figures) and it is estimated that since many victims don't report their rapes to anyone, these figures represent only 10% to 25% of the rapes that actually occur;

-- The 192,000 rapes in 1979 represent 1.1 rapes per thousand women for only that one year, if a woman lives in a large city in the US for 25 years, she has a one-in-ten chance of being raped during that time;

In recent years there has been marked improvement in the services available to victims; treatment by police and hospitals has so improved in the large cities that victims are much less hesitant to report the crime. As a result, some believe the rate of rape has not increased, but rather only the rate of reporting rapes. Victims in many cities are now able also to get help from rape crisis centers, women's centers, churches and community mental health centers. However, too often provision of service is dependent on volunteers who are "burning out." They need your support.

I agree with those who say that the $6 million authorized in Section 602 of the Mental Health Systems Act for Fiscal 1981 and the $9 million authorized for Fiscal 1982 for services to victims are a drop in the proverbial bucket; $100 million is more like what's needed to fully serve victims. But I most wholeheartedly disagree with those who then say that, since those funds are not enough to do the job well, the money would be wasted if spent on services. Instead, what is needed is a reconceptualization of services appropriate for the federal government to provide, given an existing base of local-level volunteer services.

This leads to my second point.

2) If we are to maintain the advances made to date, and use what we have learned about how to prevent and control rape, there must be federally-supported, technical assistance, outreach, and educational services to target populations and communities.

The $6 million for Fiscal Year 1981 and $9 million for Fiscal Year 1982 are sufficient for several services which would supplement those of existing volunteer-based efforts, and reduce some of their considerable burdens.

These minimal funds would be best used in two ways:

a) First, for demonstration of types of services needed but not yet provided to specific target groups (eg. families of victims) or in places as yet unserved.

b) Second, for provision of technical assistance, outreach and education services to target groups and communities where there is the desire to implement programs but where there is need for films, pamphlets, workshops and expertise which have proven effective with target groups elsewhere. One subpopulation frequently mentioned is primary and secondary school teachers who have requested help in dealing with the topic of rape.

And now for my third point.

3) There is a need, despite what some may argue, for continued social science research in this field. We have learned a great deal in the five short years since the National Center for the Prevention and Control of Rape was established at National Institutes of Mental Health.

During the past five years, for example, we have learned about motivations of convicted rapists; we have learned that victims experience predictable stages of emotional response, and we have identified appropriate supports at each stage; we have learned that some tactics have enabled some women, though attacked, to avoid victimization; we have learned about factors which enhance the likelihood of conviction in rape cases; we have identified effective strategies for educating children to avoid molestation and a host of other findings.

In its 5 years of existence, the Rape Prevention Center has funded 60 research grants. As a result, there is now information available relating to such matters as:

- education about the phenomenon of rape to help women respond to threats of assault and to foster community cooperation (see MH 29049, "Community Action Strategies to Stop Rape," by Caroline Sparks)
- identification of victim behavior which may prevent or alleviate sexual assault (see MH 29045, "Victim Response to Rape: Alternative Outcomes," by Jennie McIntyre)
- education of young children concerning avoidance of sexual assault; parental and agency information about how to work with young victims (see MH 34109, "Parents' Attitudes and Responses to Sexual Abuse," by David Finkelhor)
- non-stranger or "acquaintance rape" among adolescents and development of prevention programs specifically geared toward teenagers (see

MH 30655, "Non-Stranger Rape: The Role of Sexual Socialization," by Jacqueline Goodchilds)

- the impact of rape law reform on the criminal justice system (see MH 29532, "Law Reform in the Prevention and Treatment of Rape," by Nathan Caplan)
- practical problems related to the treatment of victims and defendants in rape trials (see MH 29727, "Structural Analysis of Jurors' Verdicts in Rape Trials," by Barbara Reskin)
- identification of effective prosecutorial methods for obtaining convictions in rape cases (see MH 32761, "A Cross Jurisdictional Analysis of the Prosecution of Rape Cases," by Toni Clark)
- how to evaluate the relative effectiveness of existing sex offender treatment programs (see MH 32669, "Evaluating Sex Offender Treatment Programs," by Mark Weinrott).

The information contained in the authors' final reports and related reports are available, at a charge for over 50-page reports, from the Grants and Contracts Management Branch, National Institute of Mental Health.

But just as cancer researchers -- with many more researchers and vastly greater resources -- were not able in five years to isolate all the crucial determinants of that feared disease or develop effective prevention programs, so we have not yet isolated all the crucial determinants, or developed and evaluated the best programs to prevent and control rape. Now -- when we are on the edge of important breakthroughs and have developed a "critical mass" of scientists striving toward the same goal -- is exactly the wrong time to stop. Further, it is appropriate that this research should be managed and coordinated at the federal level. The National Center for the Prevention and Control of Rape (currently authorized under P.L. 96-1367, Title VI, Section 601), has developed several constituencies making use of the findings of the research they have sponsored to date. These range from journalists and school teachers to volunteers in rape crisis centers and in the churches, and to academics working on models of coping behavior.

Based on an assessment of constituent and crime prevention agency needs, further basic and applied research is necessary in the following areas:

-- incidence of rape and sexual assault nationwide; why victims are unwilling to report and what can be done about the problem;

-- social environments which lead to rape and sexual assaults, including family, school, workplace, and leisure environments;

-- rape and sexual assault in correctional and other custodial institutions;

-- prevention techniques for the highly vulnerable: older women, the physically and mentally handicapped, and younger children; and

-- effective protection programs in schools and in the community.

I urge you to appropriate the full $6 million authorized in the Mental Health Systems Act, Section 601, for FY 1981 and the $1.5 million for FY 1982.

Social science is giving us the information we need to correctly identify the needs and design the effective prevention programs. I know that many of you get impatient with the amount of time it sometimes takes to develop knowledge in areas where none now exists, and that the rhythms of social science and academia are often out-of-sync with your needs as legislators and politicians. But, when impatient with our timing or desire to couch findings in qualified language, I ask you to consider the contributions of social science, the tools and concepts which have been absorbed into our conventional wisdom and public discourse so that they are now common in our vocabulary: "public opinion polls," "management by objective," "human capital," "acculturation," "political party identification," "cost-benefit analysis," "reference group," "target population," "evaluation research," "accountability," and many more. One recent article went so far as to attribute the success of Japanese industry to its application of social science findings.

In summary, I urge you all to be bold enough to commit yourselves to a goal of eliminating rape. I hope you will stop the transfer of funds from social programs to the military, and I urge you to appropriate the full amounts authorized in the Mental Health Systems Act for both Sections 601 and 602 for Fiscal Years 1981 and 1982. These amounts will allow the maintenance of past gains and important, additional progress toward both preventing and controlling rape, and enabling communities to have the information and expertise they need to serve victims. Law enforcement officials, mental health workers and others with experience with populations under economic and work stress expect that violent crime and rape will escalate as aspirations are increasingly frustrated and they perceive the federal "safety net" to be weaker and weaker.

To deny these minimal funds at this time would be tantamount to turning your backs on the women of America.

Thank you.

STATEMENT OF PEGGY L. HALSEY

The Office of Ministries With Women In Crisis of the National Division of the Board of Global Ministries of the United Methodist Church allies itself with the position of the Center for Urban Affairs and Policy Research at Northwestern University in their oral and written testimony before this subcommittee, in which they make a strong case for restoring over ten million dollars for services to rape victims and research on rape prevention to the 1981 budget (and over thirteen million in 1982), as called for by the Mental Health Systems Act. Data on incidence and the need for services is contained therein, and need not be repeated here.

As a religious organization, we have a particular perspective on rape and other forms of sexual violence as violations of human personhood and wholeness and perversions, by violence and coercion, of the covenant relationships we believe God has ordered for humankind. We believe that this perspective, shaped by Biblical and theological understandings and reinforced by knowledge of the life experiences of women in the religious community and of rape crisis and prevention programs supported by local churches across the country, needs to be a part of the record and taken into consideration as decisions about appropriations are made.

When human sexuality is seen as a gift of God and the appropriate context for the expression of sexuality is seen as mutuality and covenant, sexual violence becomes an extreme distortion of the gift of sexual intimacy. Rape and other forms of sexual assault exploit the powerlessness of a victim. There is no "covenant" between rapist and victim, only exploitation and coercion. The victim's most intimate self is violated and terrorized. Just as the inviolability of human life is broken in murder, so respect for the integrity of life is fundamentally violated in acts of rape, where a most basic part of one's life, sexuality, is violently exploited. As a community of faith, we view rape as an offense against the purpose God intended for our lives, respect for and community with one another.

Every woman moves through life knowing that she is vulnerable to rape and can at any moment become a victim; her age, race and economic class have no effect on the likelihood of her victimization. We have confirmed in recent months that church women are no exception. In a survey of United Methodist women in positions of lay leadership, one out of every twenty-four reported having been raped.

The National Division of the United Methodist Board of Global Ministries is related through funding, resourcing and/or consultative relationships to over twenty rape prevention and service programs across the country. Our colleagues in these programs report several encouraging facts which would be seriously jeopardized by the cessation of federal funds for services:

- the public utilization of rape crisis programs is at an all-time high, with for the first time a significant pool of volunteers having completed extensive training programs;
- during the last five years, when public (including federal) attention has resulted in open discussion of rape and support for victims, the percentage of rapes reported has significantly increased; at last women are beginning to feel that they will be believed and supported rather than blamed and humiliated.

During the past year, this office has done extensive data gathering and exploratory work throughout the church in an effort to determine the adequacy of pastoral and lay response to women in crisis, including victims of rape, and resources needed to improve the quality of ministry. We have been deeply disturbed to discover how few ordained clergy have received specific training in seminary or since for pastoral counselling in areas of crisis for women. The vast majority of clergy with whom we have talked have been sympathetic and sensitive to the trauma of rape victims and anxious to be supportive, but by their own admission, have known little about the dynamics of rape and have felt inadequate to assume the full burden of counselling. Those who were aware of rape crisis services in their communities utilized them for referrals, and were appreciative of the interdisciplinary team approach such cooperation provided. If rape services are curtailed as a result of federal budget cuts, religious counselors will once again have to assume full responsibility for rape counselling, something they are unprepared to do and often apprehensive about. It is a tragic prospect to contemplate, particularly when the real need is to extend publicly supported rape services to currently underserved areas, rather than to cut back on them in the relatively few communities where they are available. Therefore, we appeal to the Congress of the United States to reaffirm its commitment to victims of sexual violence and to symbolize its support of a cooperative community approach to crisis needs of citizens by restoring in full 1981 and 1982 appropriations for services to rape victims and research on rape prevention.

STATEMENT OF CAROLINE GASTON, PROGRAM COORDINATOR, NEW FUTURES SCHOOL

ACCOMPANIED BY PATRICIA CHAVEZ

Senator INOUYE. We will now hear from the Office of Assistant Secretary for Health: Carol Gaston, Sister Maureen Joyce, Jan Thompson, and Dr. James Jekel.

Senator SCHMITT. Mr. Chairman, I would like to welcome to the subcommittee, Caroline Gaston and one of her proteges from the New Future School.

I had an opportunity a couple years ago, to visit this school, not too long after they had really gotten into business, and I was very impressed with the motivation and effort that went into providing assistance to teenagers.

It is one of the examples I referred to a few minutes ago, of a program that is working.

One of the reasons that I think we must find ways to reward success in providing incentives for success elsewhere is by finding out what works and what doesn't work. It is in the national interest that we get the most for the taxpayers' money.

So I welcome you Ms. Gaston and hope you will allow Ms. Chavez to testify.

Senator INOUYE. With that introduction, you can't miss.

Ms. GASTON. Thank you very much, Senator, I appreciate the opportunity.

I would like my testimony entered into the record.

Senator INOUYE. Without objection, all of the statements will be placed in the record in total.

Ms. GASTON. I would like to summarize my testimony by stating that the importance of services for adolescents and adolescent parents focuses on three primary issues.

The first has to do with health, health of the mother and health of the child.

Adolescent pregnancy is high risk physically for both the mother and the baby. The mother is likely to suffer many complications of pregnancy, and the babies are likely to have low birth weight and other health problems.

Additionally, there is a high likelihood of repeating pregnancies, closely spaced, which have more complications.

Second, it has to do with the likelihood of school dropouts and, therefore, the young women are likely to have low educational attainments and, therefore, result in welfare dependency.

The third problem that I focused upon deals with the impact upon the family and I believe that Sister Maureen Joyce will focus upon that issue in her testimony.

We have demonstrated that at New Future School, that comprehensive programs for teenage parents can be cost-effective. We have demonstrated that the health of the mothers in New Futures School is better than national rates for adolescent mothers.

We have demonstrated that the health of the baby is better. We have less low-birth-weight babies. We have cut the repeating pregnancy rate by two-thirds.

And that is a savings to the taxpayers. That in itself saves the cost of our program. And we have increased the educational attainments of the young women who participate in New Futures.

I, therefore, urge the continuation of the present funding level, in President Reagan's 1981 budget and also urge your attention on other programs such as title 10, title 20, maternity child health and youth employment funds which also can be used and are used at New Futures School.

We provide services to adolescent parents. I would like to introduce to the panel, Patricia Chavez, and ask that she be given some time to talk.

STATEMENT OF PAT CHAVEZ

Ms. CHAVEZ. My name is Pat Chavez and I am 22. I graduated from New Futures School in 1977.

I have a four-year-old daughter. I worked as a nurse's aide 2½ years after I graduated and I am currently a student at University of New Mexico.

I was 17 when I got pregnant and I enrolled in a public high school in Albuquerque, Highland High, for a short period of time.

I found it to be crowded and stressful, and the counseling was not for my needs. And I had a feeling of being awkward.

I switched to New Futures School at 5 months of pregnancy and at that time I had no prenatal care, and when I went into the school, at that time we started going to the prenatal clinic.

The staff was good at stressing nutrition and discouraging such things as smoking, drinking Cokes, eating candy, and junk food.

The classes that I attended were especially for my needs, which were prenatal classes, and we also had exercise classes to go along with that.

Our growth and development classes and our home economics classes where we learned how to make baby clothes, blankets, et cetera.

The counseling was the best of all because we were able to call the counselors by their first name, which broke the barrier gap right there.

And I had a 1-to-1 relationship and I was able to talk to my counselor if I had any problems at all and my alternatives were also made known to me, either adoption or keeping the baby and what was involved with each of them.

We had some family counseling which one of them I attended was the mother/daughter groups and we were able to talk over our problems and that also enabled us to better understand what the other person was going through.

If I had not gone to New Futures School, I probably would not have graduated and been able to go on to college.

Senator SCHMITT. I have had a chance to chat with these two fine folks earlier today and, of course, I know about their program, Mr. Chairman.

I appreciate your calling them out of sequence, so I could participate with you in hearing their testimony.

We must keep our eye on the purpose of these types of Federal funds which is to reduce current and future costs to the Government.

If we don't keep our eye on that, then the economic justification of the program is out of our sphere. The human justification, I think, is obvious.

The real issue facing many of these programs is really, can the States participate, will the States participate, over what timeframe can we encourage the States to carry some of the burden, if not all of the burden, of these types of programs that really affect the local population.

I don't have an answer to that, but it is one issue that we are going to have to deal with again and again and again, over the next few years.

Thank you.

Senator INOUYE. Thank you very much, Mr. Chairman.

How is it funded?

Ms. GASTON. We are funded by—through all of the school systems, to the same level any other public school would be funded in terms of the academic.

In terms we have some title 20, social services funds, we have some title 10 planning funds, we have major components of youth employment funds which gives us opportunities for the girls to get some experience in the work field and also allows some of them to stay at school.

For some of them, it is a choice, work or go to school. With the youth employment funds, we are able to pay the funds to do both.

We had all of those different sources of funding.

Senator INOUYE. We are not able to provide support funding for your extracurricular activities.

Do you think the State of New Mexico will pick up the tab?

Ms. GASTON. The State of New Mexico will not pick up all of the tab. We are talking about a very short timeframe to turn around from one level of funding to another.

I think Senator Schmitt alluded to that. We will certainly approach the State of New Mexico, but I believe that we would definitely be cut back.

I am looking probably at a 30-percent cut, is my estimate for next year.

Senator INOUYE. How many young ladies do you serve?

Ms. GASTON. We will serve this year over 500 young women and nearly 200 babies and child care.

Senator SCHMITT. That's been a very rapid expansion?

Ms. GASTON. It certainly has been. We do serve to the other extent the other parts of New Mexico. About 15 percent of our population is from outside of Albuquerque.

Senator INOUYE. I congratulate you, ma'am.

Ms. Chavez, thank you very much.

Our next witness is Sister Maureen Joyce of the Community Maternity Services.

STATEMENT OF SISTER MAUREEN JOYCE, EXECUTIVE DIRECTOR, COMMUNITY MATERNITY SERVICES

Sister JOYCE. Thank you, Mr. Chairman.

From 10 years of living and working with pregnant teenagers, I have learned some basic facts about adolescent pregnancy.

The first is that there are more pregnant teenagers in rural America than our American people realize.

The program which I direct in 14 counties in upstate New York served 200 girls in one rural county alone last year.

The number seems small compared to those of New York City. Until one realizes that 200 pregnant teens in this minimally populated Appalachian county means that about 1 out of 20 teenagers there is becoming pregnant each year.

One of the happiest stories of our program has been that of Marie from one of these rural counties. She came to us because she was pregnant and in need of medical care and help in planning for her baby.

Through our program, she received the medical care, but also developed a new vision of life. She learned that people can care without exploiting others.

She saw that one's education does not have to end when she reaches 16. She saw that poverty isn't synonomous with loss of self-respect and dignity.

Today, Marie is enrolled in a community college program. She found that she has the ability, not only for herself, but for others.

She learned that poverty doesn't mean an impossible situation, just a harder one. Marie is living proof of the fact that comprehensive adolescent pregnancy programs have demonstrated a 75- to 90-percent reduction in school dropouts, second pregnancies, and welfare enrollments, which have characterized the lives of pregnant teenagers.

My 10 years has also shown me that abortion, valueless sex education and the distribution of contraceptives has not worked in combating teenage pregnancy.

In New York State, for example, where abortion is available to all, and was proposed as the way to make every child a wanted child, the last 5 years have seen a 47-percent increase in child abuse.

While abortion and valueless sex education has been promoted as the way to prevent children giving birth to children, there has been an increase in adolescent, single-parent families.

And while providing contraceptives for teens has been proposed as a way to prevent adolescents from seeking abortion, in 1979, teenagers accounted for more than one-fourth of the abortions in New York State. A State that leads in percentage of abortions nationwide.

I have also learned that teenagers cannot be helped in isolation. The family of a pregnant teenager is in crisis, just as much as is their teenager.

Adolescent pregnancy programs need to allude to the fact that the pregnant teenager has a mother, a father, and brothers and sisters.

Adolescent pregnancy programs have to show families what family means to each other and especially what families mean to their teenagers in crisis.

From my experience with adolescent pregnancy, I make the following recommendations:

One, that our Government fund programs in the rural areas.

Two, that programs treat adolescent pregnancy as a problem affecting an entire family and often reflective of problems affecting that family.

Three, that the Office of Adolescent Pregnancy Programs be maintained to assure a comprehensive provision of service in areas neglected in the past.

Four, that we provide for the pregnant adolescent who does not seek abortion as a moral option for her and, five, that we support adolescent pregnancy programs, aimed not only at providing basic medical health, but at providing family and individual counseling, education and skilled development to end a person's reliance upon the welfare system.

Thank you.

Senator INOUYE. I thank you very much, Sister Maureen. I didn't realize, until you mentioned it, that adolescent pregnancies have a greater incidence in rural America?

Sister JOYCE. It is much more obvious in the urban area and we hear about it more.

I think per population, it is much larger than we would imagine.

The unfortunate part is the resources there are not in place to address this population, not even the medical resources.

Senator INOUYE. Well, I thank you very much.

Is Jan Thompson here?

STATEMENT OF JAN THOMPSON, TULSA, OKLA.

Ms. THOMPSON. Thank you.

I am Jan Thompson from Tulsa, Okla. I am speaking to you as a community volunteer and mother of four children and am acting as an ambassador for programs for school-age parents. I strongly urge you to provide adequate appropriations to keep the Office of Adolescent Pregnancy Programs alive. It is very important to continue the service-oriented funding of programs for adolescents which have recently been funded.

As a mother, I believe that safeguarding the healthy physical and mental development of children is the most important responsibility society faces. Because of this belief I became involved with the problems and concerns of pregnant teenagers. It is a problem that affects, directly or indirectly, all social, economic, and racial groups. By providing programs with cooperating agencies we are helping teenage mothers through a time of crisis and preparing them for future growth and how to be responsible, productive adults.

Teenagers who do not receive adequate education, health care, and counseling services are prospective candidates for future mental and physical health treatment, crime and delinquency, and welfare dependency. It seems to make sense to assign a high priority to retention of funds which are largely used for prevention of a problem, like adolescent pregnancies. In the long run, preserving these programs will most probably save the Government a significant amount of money.

I think we would all stress with conviction that becoming pregnant at 12, 13, or 14 is not a good idea. But young girls do get pregnant and they need to know that their communities care about them and that they can meet the challenges of healthy family life.

My strong preference is for the current administration and Congress to continue to support adolescent pregnancy programs already being funded. However, if the block-grant route is taken, then careful consideration needs to be given those projects receiving demonstration grants which are only now getting underway under the grant program. The Government needs to protect its investment in these projects. Further reduction of funds will not be cost effective in the long run. No one professional group can mobilize all the resources needed for our pregnant teenagers, but a coordinating body cooperating with services of other groups can, when properly funded, be effective.

We cannot sit idly by as the birth rate of children bearing children increases.

Senator INOUYE. May we have a copy at this table. We have received a prepared statement from Linda Stern, and without objection that statement will be made part of the record.

Our next witness is Dr. James F. Jekel, professor of epidemiology and public health.

STATEMENT OF DR. JAMES F. JEKEL, PROFESSOR OF EPIDEMIOLOGY AND PUBLIC HEALTH, DEPARTMENT OF EPIDEMIOLOGY AND PUBLIC HEALTH

Dr. JEKEL. Because of the lateness of the hour and because of the concern of the committee, I am going to shorten and alter my testimony.

I appear before this committee speaking from 13 years of research and concern for the problems of and programs for adolescent parents and their children.

I press my strong hope that this Nation's fledgling commitment to help these extremely needy to have comprehensive health services will not die during this Congress, but rather that this commitment will be maintained and strengthened, though altered, in terms of its legislative expression.

The Federal effort will not be and was never intended to be the only primary source of funds for helping this population to reenter the mainstream of American teenage life. It can and should be a source of assistance to link available community resources and supplement where existing services are seriously deficient. Federal funds should help to serve as the mortar and bricks and hold this community together.

In this land there are thousands of health workers, teachers, and social service persons who are helping teenagers confronted with the greatest crisis of their lives to survive, have healthy babies, reestablish themselves in the community. To these people the Federal funds are resources to help them put together available services into a comprehensive package.

We are not talking of a large share of the Federal budget. Despite the fact that all teenagers deliver approximately 20 percent of the Nation's babies and those teenagers under 18 years deliver almost 8 percent of the Nation's children, and these are the mothers and infants that have the most health problems of the group, the current Federal authorization is about one one-hundredth of 1 percent of the Federal budget.

The appropriations for this bill during the last 3 years were much smaller, less than one eight-hundredth of 1 percent of the Federal budget during this time. Surely for such a big problem we can do better.

I will now depart from my prepared testimony to summarize a couple of points.

It is difficult to discuss an appropriation without knowing the form of the authorization. But there are some essentials to keep in mind regardless of the form. First, it is crucial to maintain a national commitment to health and independence to those who become parents while adolescents, and their children.

Second, the current level of funding should be maintained until a new authorization becomes effective.

Third, under some kind of health block grant program, preferably one that includes all maternal and child health services together, even though the State would have more control, the adolescent pregnancy service appropriations must be targeted and safeguarded so that they cannot be bled off to unrelated programs.

Fourth, there should be a Federal office of adolescent pregnancy services to give technical assistance and direction to States and communities who need this assistance, and there are many who do need this assistance.

I would like to summarize briefly some of the findings regarding effectiveness of some of the studies that we did with assistance from the children's bureau and subsequently Office of Maternal and Child Health.

We studied two programs and a control group that did not have special services. The programs had reduced infant mortality and better maternal health compared to the control group. In the control group approximately 20 percent of the young mothers graduated from high school, whereas in the study groups there were 50 percent who were in school or graduated 2 years later.

The subsequent pregnancies were reduced in the study groups compared to the control group and approximately one-third of the young mothers were working 2 years later, and approximately two-thirds had been employed at some time in the 2 years following their pregnancy.

Now, I will send to the committee extensive materials from our studies regarding the impact of the program and I believe some of the programs that have been more recently done in the early 1970's, some of the more recent programs have even better results.

Thank you.

Senator INOUYE. Thank you very much, Doctor.

In your prepared statement you quote your testimony which was given 3 years ago, suggesting that the administration of this program be turned over to the States after they have developed a State plan for adolescent pregnancy.

Dr. JEKEL. That is right.

Senator INOUYE. How long would that take?

Dr. JEKEL. I believe there would have to be some money to allow the States to develop the State plan. I would say that already many States do have a State plan. Connecticut is one of them, and has a State-run program, assistance to the teenage mothers. But I would say probably 6 months' leadtime would be needed for the State to develop the State plan.

Senator INOUYE. If the States are not able to develop this plan, what then?

Dr. JEKEL. I believe that the local communities will put pressure on to develop such a statewide program, which I know is the route by which they can get better assistance for what they are doing. I believe that if it is clear that the States must develop a State policy, that this will force States which heretofore have ignored the problem of teenage pregnancy to a greater or lesser extent to take a look at it and deal with it in terms of their own needs and priorities.

Senator INOUYE. I can assure you ladies and doctor that this subcommittee will study this problem very carefully.

The amounts involved are not that huge. I think this Government can afford to add a few dollars to the budget, I don't think it will destroy the economy. Thank you very much.

[The statements follow:]

STATEMENT OF CAROLINE GASTON

I appreciate the opportunity to talk with you today about teenage pregnancy and teenage parenthood. My testimony is in support of the appropriation for the adolescent pregnancy legislation - PL 95-626 - enacted by Congress in 1978. Let me make it clear that my own program for teenage parents, New Futures School, does not receive funds under this legislation. I am here because I am convinced of the necessity, and the cost-effectiveness, of providing comprehensive services to adolescent parents.

Adolescent pregnancy is an issue of increasing concern to millions of Americans. Throughout New Mexico committees of volunteers, parents, teenagers, doctors, nurses, educators, and social services agency personnel are meeting to address their concerns about what happens to pregnant teenagers, teenage parents, and their families in their communities. These communities include Alamogordo, Las Cruces, Carlsbad, Grants, Gallup, Española, Santa Fe, Estancia, and Albuquerque. A statewide committee which includes interested leaders from the communities of Raton, Taos, Farmington, Reserve, Silver City, Las Vegas, and Tierra Amarilla in addition to the afore-mentioned communities is also meeting regularly. Española, New Mexico receives funding from the Office of Adolescent Pregnancy Programs for a comprehensive program of pregnant teenagers and adolescent parents. Its application was successful due, to a great extent, to the evidence of widespread community support for the program.

Why are so many people, from such varied communities and backgrounds, concerned about what happens to pregnant teenagers and teenage parents? There are several reasons.

The first set of reasons has to do with health issues. Teenage mothers seventeen years of age and younger have higher health risks for both themselves and their children. Teenage mothers have higher rates of toxemia, prolonged labor, and other complications of pregnancy. Their babies are more often born prematurely and/or with low birthweights, often associated with birth defects, than those of adult mothers. These are well-established facts. It is also well-established that these health problems are not only costly in human terms but costly to the taxpayer in terms of increased hospital and medical costs.

The second set of issues has to do with education. Eighty per cent of hose who become pregnant at seventeen or younger do not graduate from high school. Employment in this country is becoming more and more dependent upon completion of a high school education. Because so many teenage mothers lack adequate education, they are very likely to become welfare recipients, not by choice, but by necessity. This too is costly in terms of human dignity and taxpayers dollars.

A third set of issues has to do with family life. Whole families are affected when a teenager becomes a parent. Programs for adolescent parents stress services to strengthen families--both the new family which is beginning and the existing family network into which the child is born.

As Senator Schmitt knows, New Futures School in Albuquerque is one of the model programs for pregnant teens and adolescent parents upon which the adolescent pregnancy legislation was based. We have demonstrated at New Futures School that comprehensive services can significantly lessen many of the risks faced by young mothers and their children and thereby save many taxpayer dollars.

There are fewer low birthweight babies born to New Futures School mothers than to teenage mothers in general. NFS mothers have had lower rates of toxemia than national rates for teenage mothers. Both of these statistics mean lower medical costs. Educational attainment is higher for teenage mothers who attend NFS. Repeat pregnancy rates for NFS clients are less than a third of national rates. We have observed that improved parenting skills, and young women with strengthened self-images and positive goals for the future are also products of this comprehensive program for teenage parents.

Similar positive, cost-saving outcomes can be expected from the programs recently funded by the Office of Adolescent Pregnancy Programs under PL 95-626. Adequate appropriations for FY 1981 and '82 are needed to ensure that these programs develop a strong base from which they can continue to provide services after federal funding is withdrawn. (This legislation provides for declining federal participation over a five-year period.)

The benefits of this legislation go beyond the grantees which it is funding directly. Because the legislation and the guidelines established by the Office of Adolescent Pregnancy Programs require evidence of community planning and utilization of a variety of community resources, hundreds of communities established local committees composed of parents, teenagers, volunteers, and health, social services, and educational professionals. Over three hundred of these communities submitted proposals to OAPP in the last funding cycle. Two hundred of these proposals were rated acceptable by reviewers. OAPP had money to fund only twenty-seven of these projects. I know from personal contacts, however, that many of the non-funded applicants have continued with their planning and coordination efforts and have developed beginning programs for the pregnant adolescents and adolescent parents in their communities. The dollars appropriated to OAPP have a far larger impact than it would appear if one looks only at the thirty-one OAPP-funded projects.

Many appropriations which this Committee is now or will be considering affect services to adolescent parents. The adolescent pregnancy legislation mandates cost-effective programs in that it requires projects to demonstrate that they are using a variety of funding sources in addition to PL 95-626. As a model for this type of networking, New Futures School utilizes or depends upon for service agencies which utilize such funds as Title XX (Social Services), Title X (Family Planning), Title V (Maternal and Child Health), Vocational Education, and Department of Labor Youth Employment funds. These funds are, we understand, targeted for cuts ranging from twenty per cent to one hundred per cent for FY '82. If these cuts take place, we project that New Futures School will have to cut the number of adolescent parents served by thirty per cent. These cuts would affect other adolescent parent programs similarly.

I urge the Committee to keep in mind, as it considers the appropriations for PL 95-626 and other legislation which affects services to adolescent parents, that such services have proven to be, in such programs as New Futures School, highly cost-effective. A dollar targeted to this important legislation leverages other dollars in the local community and saves countless dollars in welfare and health care costs for years to come.

I urge an appropriation of thirteen million dollars for PL 95-626 for FY '82. I further urge that appropriations for programs listed in the above paragraphs be targeted to adolescent parents and maintained at their current funding levels.

STATEMENT OF SISTER MAUREEN JOYCE

Good afternoon. My name is Sister Maureen Joyce. I am here to speak about the plight of the 13 to 19 year olds who become pregnant each year. From ten years of living and working with these teenagers, I have learned some basic facts about adolescent pregnancy.

The first is that there are more pregnant teenagers in rural America than our American people realize. Problems in the cities have been obvious to us because we cannot escape them. But the problems in the rural areas are equally if not more pressing, despite the fact that they are hidden from our view.

The program which I direct in 14 counties in upstate New York served 200 girls in one rural county alone last year. The number seems small compared to numbers served in New York City, until one realizes that 200 pregnant teens in this minimally populated Appalachian county means that about one out of 24 teenagers there is becoming pregnant each year.

Teens in these rural counties are open to help, however, if only for the fact that it hasn't been offered to them previously. One of the happiest stories of our program has been that of Marie from Delaware County. Marie came to us because she was pregnant and in need of medical care and help in planning for her baby. She was a high school drop-out. She'd been taking turns living with her mother, girl friends, her boyfriend, and when her boyfriend went to jail, his mother. She lived in the fields of Appalachia and the streets of her little home town. In her world, drop-outs were the rule; teenage pregnancy, common; and incest and other forms of sexual abuse, seemy but accepted. Through our program, however, Marie not only received medical care, she developed a new vision of life. She learned that people who care about others don't exploit them. She saw that one's education doesn't have to end when one reaches 16. She saw that poverty isn't synonomous with loss of self-respect and dignity.

Today Marie is enrolled in a community college program. She's found that she has ability to be used, not only for herself but for others. She's learned that poverty doesn't mean impossible situations, just harder ones. Marie has also learned to value herself as someone to be respected rather than exploited.

She gave birth to a son on a cold winter night one year ago. She surrendered him for adoption because she knew that then she wasn't able to give him the life she'd come to see was possible for people in America. "If I meet him again in 20 years, he'll understand," she told me when she surrendered him. "Maybe we'll both have achieved something with our lives by then".

The ability to look beyond, to sacrifice for another's benefit, to see worth in oneself and another came through contact with a program based on the same solid Judaeo-Christian values upon which this country was founded. With them, Marie did the almost impossible - she moved out of the welfare system, received a diploma, saw that when one sets a goal and works toward it, one reaches success.

My ten years have also shown me what hasn't worked in combatting teenage pregnancy. One of our country's most expensive lessons has been that widespread promotion of contraceptives to teenagers, availability of abortion to all, and sex education programs which ignore a value system do not work.

In New York State, for example, while abortion was proposed as the way to make every child a wanted child, the last five years have seen a 47 per cent increase in reported instances of child abuse. While abortion and valueless sex education has been promoted as the way to prevent children giving birth to children, there has been an increase in single parent families. And while providing contraceptives for teens has been proposed as a way to prevent adolescents from seeking abortions, the rate of abortions for teenagers has reached a level three times higher than the rate of abortion for the overall population in the very state which leads in the abortion race. Indeed, in 1979, teenagers accounted for more than one-fourth of New York State's abortions!

Recently I sought funding for a program to offer an adolescent pregnancy program which would stress values, the dignity of the human person, and the need for self-control in every aspect of a person's life. The holder of the purse strings said no funding was possible until I could prove that my idea would work. Since common sense has no data bank to back it up, I couldn't meet the requirement. But I can tell you that there's overwhelming data which shows that what our country has tried in the past 20 years to curb adolescent pregnancy hasn't worked.

It is time for a change. It is time for programs which have as an underlying moral principale the belief in human nature. To paraphrase G.K. Chesterton, right now we do not have a generation of teenagers where morality has been tried and found wanting. We have a generation where morality hasn't even been tried.

We need programs which hold out ideals, programs which say that it is not all right to be sexually active just because you feel like it anymore than it was all right to bean little brother with blocks when your five-year-old heart urged you to do so. We need programs which say "I know you want to be loved, need to be loved, and need to feel loved." We need programs which say, "I will show you what love means". But we also need programs which make it clear that loving sexual expression is different from sexual exploitation.

The nights I have peeked into a bedroom at the maternity residence wher I live and have seen a very much pregnant 14 year old hugging her teddy bear has given me insight. So have the days I have watched a 15 year old choose to keep a newborn child in hopes that baby will be someone to love her. The insight is that teenage pregnancy is a symptom more than a problem. The real problem is the alienation, the isolation, and the loneliness in impersonal society where the slightest sexual advance is grasped at as the chance for desperately needed warmth and affection.

I have also learned that teenagers cannot be helped in isolation. The family of a pregnant teenager is in crisis just as much as is their teenager. Adolescent pregnancy programs need to allude to the fact that the pregnant teenager has mother, father, brothers and sisters. We joke that we can't choose our relatives, but the fact is that we can't choose to go without them.

I have experienced great affection from the girls I have lived with, counseled, and sat with during the labor and delivery of their child. I cherish these experiences above all that I have been priviliged to have as a Sister of Mercy. But I also know that despite this fondness, I cannot provide what a family can - that steadfastness which is developed over years of common experiences. Sadly, however, families under rate themselves in this regard. In fact, George Gallup, the ever-faithful reader of America, tells us that the vast majority of American parents think they're doing a poor job of raising their children. Adolescent pregnancy programs have to show families what family members mean to each other, and especially what families mean to their teenagers in crisis.

Last week I received a telephone call from a teenager who had left our maternity residence after the birth of her child. She was lonely. She'd been living alone in the house ever since her mother moved out to live with her boyfriend. In that same week, I stayed with a teenager who had tried to commit suicide six times. She kept asking, "Why won't my mother love me"? Still in the same week, I watched a family together. Mom said,"You can't bring the baby home". Dad said, "yes you can". Daughter cried, "If you two can't agree with each other, how can I agree with you"? All of these parents are in crises. All need to be helped so that they can help their children.

For whatever reason, the past 20 years have been marked by a destabilization of American society. No group has suffered more from this than our present teenagers. We owe it to them, to ourselves, to the future of our country, and to the God who has blessed our country over and over again to undo the harm which has been done.

One way toward this stabilization can be through addressing the problem of teenage pregnancy. We must show a respect for life, in rural as well as in urban America. We must provide realistic alternatives to abortion and valueless promotion of contraceptives. We must address our youths as members of families. I do not pretend that efforts will cure all of America's ills, but they will bring us further than will programs which have been tried and found wanting, or new programs never tried at all.

STATEMENT OF DR. JAMES F. JEKEL, PH. D.

I appear before this committee speaking from 13 years of research and concern for the problems of, and programs for, adolescent parents and their children. I express my strong hope that this nation's fledgling commitment to help this extremely needy population to have comprehensive health, education, and support services will not die during this Congress and this Administration, but rather that this commitment will be maintained and strengthened, even though altered in terms of its legislative expression.

The Federal effort will not be, and has never intended to be, the only or the primary source of funds for helping this population to reenter the mainstream of American teenage life, but it can and should be a source of assistance to LINK available community resources and to SUPPLEMENT where existing services are seriously deficient. Federal funds should serve as mortar to help to hold the existing bricks of community services together. In the communities of this land are thousands of dedicated health workers, teachers, social service persons and others who are helping teenagers confronted with the greatest crisis of their lives to survive, to have healthy babies, and to reestablish themselves in their education. To these dedicated community workers, the Federal funds are added resources to help them to put the available services together into a comprehensive package. Moreover, the existing bill has been an encouragement to these often unappreciated workers, a statement that the nation has not forgotten them or the young people they serve. Note that we are not talking of of a large share of the Federal budget: despite the fact that ALL teenagers deliver approximately 20% of the nation's babies, and mothers under 18 years deliver approximately 8% of the nation's babies, and these are the mothers and infants who have the most problems as a group, the 3 year Federal AUTHORIZATION for P.L. 95-626, Title VI was about 1/100th of ONE PERCENT of the Federal budget for that period, and the APPROPRIATIONS for the bill were much smaller, for the 3 years less than 1/800th of one percent of the Federal budget during that time.. Surely, for such a big problem we can do better!

This nation's first legislative commitment to help teenage parents and their children as a defined target group was Titles VI-VIII of P.L. 95-626 (92 STAT. 3595-3602) dated Nov. 10, 1978, about two and one-half years ago. The act created a program of projects around the nation based on applications submitted by interested communities. Because of the small appropriation, only a few projects have actually been funded to date, and there are many persons around the nation beginning to wonder if this was all a legislative hoax. If these small efforts are curtailed or discontinued at this time, their worst suspicions will have been confirmed. It is true that the implementation of the program of projects has been somewhat rocky, but this was no surprise because of the small appropriation and the administrative complexity of the legislation as passed. Indeed, in testimony submitted to the Committee on Interstate and Foreign Commerce, House of Representatives, and reported in the committee report of June 28, 1978, (Serial No. 95-113), I predicted as much:

> "The idea of improving 'linkages' is a good one, but if the (administrative) mechanism is not carefully defined in the bill, the development of rugulations, and their subsequent administration, could become a nightmare and be seriously delayed." (p. 76)

In my judgment, this is what did happen, primarily because a complex program of projects is exceedingly difficult to develop and administer quickly and efficiently.

I believe we are coming to realize that a national program of projects, in which the Federal government judges applications from the individual communities of this vast nation, is an administrative jungle. The current Administration wishes to use instead the approach known as "block grants" to lower administrative costs, improve program integration, reduce fragmentation and overlap, and return more of the priority setting to states and communities who are close to the problems. This is an admirable goal, and block grants may well be able to achieve this IF (but only if) certain safeguards are inserted to prevent the disasters of both the early FORMULA GRANT PROGRAMS (where monies tended to stay at the state level instead of "trickling down" to the people needing services), and the GENERAL REVENUE SHARING approach (which gave states and communities so much latitude in their allocation and use of the funds - with little or no accountability - that desperately needed programs could be totally ignored.)

How can these dangers be avoided in the block grant programs? FIRST, there must be a well developed STATE PLAN, with Federal approval, before the block grant monies are transferred. (This has been done in many areas, such as Title V MCH programs, for a long time.) The Federal government must mandate that the States address EACH AREA OF CONCERN stated in the Federal legislation, and develop a comprehensive set of services addressing the needs, given the particular mix of needs and priorities in that state. SECOND, the Federal government must assure that most of the monies reach the people for whom they are intended, rather than being trapped in governmental bureaus; note, however, that adequate money must be provided for adequate and efficient administration of the programs. THIRD, there must be adequate, but not burdensome, ACCOUNTABILITY to the Federal government that the monies did, indeed, carry out the State Plan. Without these safeguards, disaster will occur in crucial health programs, and infrastructures that took decades to build will disappear overnight without adequte replacement.

Where does the adolescent pregnancy bill fit into all of this? I am concerned that unless some very specific care is taken, the entire area of Maternal and Child Health in this nation will be thrown into disarray, whereas it need not be if a few simple cautions are taken. In short, I recommend that all of the Federal Maternal and Child Health programs be included together in one separate MCH block grant, into which will be folded not only such existing programs as Title V but also the Adolescent Pregnancy Bill, with mandates to carry out the legislative intent of 95-626 from the State level. NEITHER MATERNAL AND CHILD HEALTH CONCERNS IN GENERAL, NOR ADOLESCENT PREGNANCY EFFORTS IN PARTICULAR, ARE LIKELY TO FARE WELL AT THE STATE POLITICAL LEVEL UNLESS THESE SAFEGUARDS ARE TAKEN. Why not: adolescents and children do not vote, and neither do they lobby. You, Congress, must set the general priority areas, but the States can better work out the details of priority and administration. Can States run effective programs for adolescent parents and their children from the state level, working with the communities? The answer is that they can, and some states, including Connecticut, from which I come, have done so for years. I am attaching to this testimony a paper written by that program's director, Mrs. Mary R. Langton, demonstrating what was done with a modest amount of money in that state. Moreover, lest the committee think I am recommending this only because block grants are now in, I would like again to refer to my written testimony cited above, given almost three years ago:

> "In my judgment, the best approach to the administration would be to turn the responsibility over to the STATES, after they have developed a STATE PLAN for adolescent pregnancy...."(p. 76)

Any deficiencies with the existing legislation for adolescent pregnancy services lie not with the intent, which is correct, nor with the strategy of promoting linkages and supplementing services, which is correct, but with the tactics, namely the "program of projects" approach. Under a maternal and child health block grant with adolescent pregnancy as a mandated concern, better integration between existing services could be achieved, with greater impact per dollar spent.

The problem of adolescent pregnancy has not disappeared, and as a nation we dare not forget this population group. Adolescent ent pregnancies must receive adequate prenatal care, labor and delivery care, and postpartum care including family planning. But they also need comprehensive services in education and social services. For example, we found that those teenagers who were enabled to remain in school had fewer and less rapid subsequent pregnancies than those teenagers who dropped out of school, integration of a wide spectrum of services is the most effective approach

I close by urging the Committee to maintain our commitment to meeting the needs of adolescent parents and their children by mandating the kinds of services discussed in Title VI, P.L. 95-626 as a part of an overall maternal and child health block grant. Thank you.

STATEMENT OF JAN THOMPSON

I'm Jan Thompson from Tulsa, Oklahoma; I am speaking to you as a community volunteer and mother of our children and am acting as an Ambassador for programs for school-age parents. I strongly urge you to provide adequate appropriations to keep the Office of Adolescent Pregnancy Programs alive. It is very important to continue the service-oriented funding of programs for adolescents which have recently been funded.

As a mother, I believe that safeguarding the healthy physical and mental development of children is the most important responsibility society faces. Because of this belief, I became involved with the problems and concerns of pregnant teenagers. It is a problem that affects, directly or indirectly, all social, economic, and racial groups. By providing programs with cooperating agencies we are helping teenage mothers through a time of crisis and preparing them for future growth and how to be responsible productive adults.

Teenagers who do not receive adequate education, health care, and counseling services are prospective candidates for future mental and physical health treatment, crime and delinquency and welfare dependency. It seems to make sense to assign a high priority to retention of funds which are largely used for prevention of a problem, like adolescent pregnancies. In the long run, preserving these programs will most probably save the government a significant amount of money.

I think we would all stress with conviction that becoming pregnant at 12, 13, 14 is not a good idea. But young girls do get pregnant and they need to know that their communities care about them and that they can meet the challenges of healthy family life.

My strong preference is for the current administration and Congress to continue to support Adolescent Pregnancy Programs already being funded. However, if the block grant route is taken, then careful consideration needs to be given those projects receiving demonstration grants which are only now getting underway under the grant program. The government needs to protect its' investment in these projects. Further reduction of funds will not be cost effective in the long run. No one professional group can mobilize all the resources needed for our pregnant teenagers, but a coordinating body cooperating with services of other groups can, when properly funded, be effective.

We cannot sit idly by as the birth rate of children bearing children increases.

STATEMENT OF JESSIE SCOTT, ASSOCIATE PROFESSOR AND COORDINATOR FOR GOVERNMENTAL RELATIONS, UNIVERSITY OF MARYLAND SCHOOL OF NURSING, AMERICAN NURSES ASSOCIATION

Senator INOUYE. Now, we will receive testimony from the Health Resources Administration. Professor Jessie Scott, University of Maryland, representing the American Nurses Association.

Jerome Ziefman, National Senior Citizens Law Center. Gordon Thomas, American Association of Nurse Anesthetists. Dr. Robert A. Mengebier, Burns Clinic Medical Center.

Dr. James Kimmey, president of the American Health Planning Association; Marvin Kirby of the Mid-American Health Systems Agency; Dr. William Kane, Association for the Advancement of Health Education; and Mr. Michael Gemmell, Association of Schools of Public Health.

Our first witness, Professor Scott.

Ms. SCOTT. I am Jessie Scott, associate professor of nursing at the University of Maryland. And today I represent the American Nurses Association. We appreciate the opportunity to present our views on budget proposals. They are spelled out in some detail in our full statement, and we ask that it be included in the report.

Senator INOUYE. All of your statements will be made part of the record in full.

Ms. SCOTT. Thank you.

Given the state of the economy, we understand and support the budget review process now underway. However, we hope that the decisions about cuts in spending will be clarified on the basis of national priorities.

We believe that health is a major priority and we are very concerned about the potentially large reductions in support for programs to aid such groups as poor women and children and programs to sustain and improve human services.

We have serious misgivings about the consolidation of mental health programs under the block-grant approach. Although some States may be able to effectively target their resources, experience has shown that this will not be uniformly true across the country.

We are concerned that this approach will result in limiting access to services such as community health, migrant health, and maternal and child health. It is well documented that lack of access to such services results in higher utilization of costly institutional care.

We also ask that this committee look closely at plans to eliminate clinical training under these programs. Given the need for health care providers and the shortage of nurses with advanced training in such areas as maternal and child health and mental health, we believe the impact would be even more far reaching.

We are deeply distressed by the proposed reductions in support for nursing schools and students. Budget proposals would rescind $63.2 million of current year funding and would reduce 1982 appropriations to only $15.2 million. The withholding of already authorized funds for fiscal year 1981 would have a serious, if not disastrous, effect on schools of nursing and nursing students causing discontinuance of programs already underway.

Given the already severe shortage of nurses that is being experienced in virtually every State of the Union, we seriously question the wisdom of these huge reductions in Government support. It is still not clearly understood by many that scientific and technological advances in the treatment of disease have placed a corresponding increased demand on nurses.

Hospital stays are shorter with the results that a majority of patients are sicker. Technologies used in their care are more complex. Along with intensive use of hospitals has grown an increasing demand for nurses in other settings in the community, requiring modifications in education and practice.

We believe that underutilization or misutilization of registered nurses is a contributing factor both in the current nursing shortage and in the continued escalation in health care costs. To help improve this situation, Federal aid to nursing education has been essential, both in helping to maintain an adequate supply of nurses and in supporting opportunities for the preparation of large numbers of nurses to assume their increasingly complex responsibilities.

Virtually all of the programs under the Nurse Training Act would be severely cut or eliminated, including student support, advanced training to prepare teachers and supervisors, nurse practitioner programs and special projects that aid in the development of programs of primary care. Also affected would be programs of health education and prevention designed to help meet the needs of high-risk groups.

Support for nursing research, which provides the basis for improvement of nursing practice, would be completely wiped out under the administration budget proposals.

Mr. Chairman, we agree that all should be willing to accept their fair share of budget cuts, but we believe those proposed for health and nursing programs are excessive and will result in further nursing shortages with a result that endangers patient care.

Thank you.

Senator INOUYE. What is the nursing shortage at the present time? What are the numbers?

Ms. SCOTT. If one looks at the estimates put out by the American Hospital Association, they have reported a shortage of 100,000 unfilled budgeted positions. If you add to that the unfilled positions in nursing homes and community health agencies and in schools of nursing, the nursing shortage in this country is severe.

If you then think about what may be happening in terms of any kind of a health insurance program, if you think about any kind of enlargement of health maintenance organizations, and if you think about the expanding role of the nurse in health care, then the shortage is even more acute.

So there are varieties of ways I think in which the nursing shortages can be looked at, but there is, in fact, a nursing shortage in this country.

Senator INOUYE. What are the causes of the shortage?

Ms. SCOTT. I think the cases are multiple and bear some relationship to each other. But if you think about the intensive use of hospitals now, where the patients are sicker and stay for a shorter period of time, if you think of the demands for nurses who work in coronary care units, intensive care units or burn therapy, premature infant nurseries, the demands for nurses has increased markedly as health care technology in this country has changed.

So, the shortage is exacerbated, I think, by the number of things happening in the health care field itself. The demands are increasing.

Senator INOUYE. What about the pay?

Ms. SCOTT. Pay for nurses is low. The starting salary for nurses in this country is around $13,000 a year, after having had a number of years of training. And the pay doesn't increase as one gains experience.

So the pay increases for nurses to keep them in the field is not commensurate. And we know full well that people who work in other fields, not requiring the same level of training, not requiring the same levels of responsibility, earn far more money.

Senator INOUYE. Are the doctors treating nurses a little more civil?

Ms. SCOTT. I think physicians are devoted to their work and their concern about and care for their patients. But, they look upon those who work with them as only assisting them.

Interestingly enough, nurses look upon themselves as assisting patients rather than assisting physicians, so I think that there is a split in how nurses view themselves and how physicians view nurses.

Nurses tend to relate to their patients.

Senator INOUYE. Have you seen the article in the Parade Magazine?

Ms. SCOTT. Yes; also the one that was in the New York Times about 1½ weeks to 2 weeks ago.

Senator INOUYE. Is that article correct?

Ms. SCOTT. I think it is. It reflects the demands placed on nurses in practice, the demand placed on them by institutions where they work as well as demands placed upon them by the people with whom they work. I think the demand placed by institutions on nurses is a very difficult problem and one that should be solved.

Thank you.

Senator INOUYE. Our next witness is Mr. Jerome Zeifman; welcome, sir.

STATEMENT OF JEROME ZEIFMAN, NATIONAL SENIOR CITIZENS LAW CENTER

Mr. ZEIFMAN. Thank you, Mr. Chairman.

I am testifying today on behalf of the National Senior Citizens Law Center, and I am an attorney with the Law Center. Previously, I served as counsel for the House Judiciary Committee for a number of years, and general counsel of that committee.

Mr. Chairman, the National Senior Citizens Law Center is the national support center, specializing in the legal problems of the elderly, poor. Many, if not most of our clients, are elderly persons who have been gainfully employed during their entire working lives.

They are not so-called chronic welfare cases. Most of our clients are people whose advanced years have brought them into poverty along with the deterioration in their health. Such persons are, I submit, truly needy and are dependent for their very survival on many of the programs in which cuts have been proposed.

Mr. Chairman, in our organization, we cannot, in good conscience, go down the list of proposed budget cuts and select some as being worse or better than the others, and we cannot give you a list of priorities.

In our view, some of our clients' very survival will be threatened regardless where these cuts take place. We have listed in our submitted testimony our opposition to cuts in a wide variety of areas, all affecting the elderly poor.

Since I am on the panel today with respect to health planning, I do want to offer some observations in that regard.

We oppose the administration's proposal to phase out the Federal health planning system over the next 3 years. One special perspective perhaps which I would like to bring to this is that I think it is very important to recognize that currently the health industry is not as competitive as many other industries in the United States.

That lack of competitiveness in the health industry, as I see it, stems from essentially two factors. One factor is the nature of health problems, that is, people who are sick don't often have the time or inclination to shop around.

Another major factor, I think, is a result of legislation enacted by Congress. Some years ago, Mr. Chairman, the House Judiciary committee on which I served as general counsel enacted or processed legislation known as the Ferguson Act which essentially exempted the insurance industry from antitrust regulation and also from the major provisions of the Robinson-Patman Act.

As a result, the health insurance industry is not as competitive as other industries in our society. In addition, because of the burgeoning problems in health care costs, I think it is very important for the Congress to explore every possible device to keeping health care costs down.

Now, the health planning programs of the Federal Government, in our view, especially in the nursing home area where our organization is most familiar, is a significant device for reducing health care costs.

In our prepared testimony, Mr. Chairman, we set forth examples of the reduction in health care costs and the beneficial results produced in a number of States. I would rather not review them at this point.

Another particular aspect of this which we are quite interested in is the fact that as a result of health care planning, many local programs have been emphasizing alternatives to institutionalization. In other committees, we are supporting legislation to promote alternatives in institutionalization. These alternatives will substantially reduce health care costs, if properly administered.

Since the health planning system is currently something which in a number of areas has been used to foster alternative institutionalization, in our view, it certainly ought not to be discontinued. That concludes basically my remarks on the health care—on the health planning process.

As I indicated, we also are on record as supporting a number of other cuts—I am sorry, opposing a number of other cuts, in a number of other areas.

Thank you very much.

Senator INOUYE. I am certain you have noted by now that we have not asked any of you to suggest where we can make cuts, because that would be a cruel exercise. That is our responsibility.

We have to elect to do that. We just hope that in making our decisions, we will make a wise one, that is all. But as one witness indicated, there is one unavoidable fact. We all get old, so we can relate to your problems.

I am reaching the stage where I will be qualified for medicare soon, so you have got a vote.

Mr. ZEIFMAN. We would be happy to give you legal assistance.

Senator INOUYE. Thank you very much, sir.

Our next witness is Mr. Gordon M. Thomas, representing the American Association of Nurse Anesthetists.

STATEMENT OF GORDON M. THOMAS, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Mr. THOMAS. Yes, I am here.

Senator INOUYE. Please proceed.

Mr. THOMAS. Mr. Chairman, I am Gordon M. Thomas, an attorney appearing today on behalf of the American Association of Nurse Anesthetists. Prior to beginning my formal remarks, Senator Inouye, I would like to express our appreciation to you personally for the support, cooperation, and assistance which you have given nurse anesthetists in the past.

Mr. Chairman, we support an appropriation for nurse anesthetists in fiscal year 1982 to the extent that funds may be authorized by pending health manpower legislation. As detailed in our formal statement submitted for the record, there is a serious national shortage of some 7,000 to 10,000 nurse anesthetists.

Nationwide nurse anesthetists are providing safe, reliable, and economical treatment to one-half of all patients who require anesthesia. In rural areas, especially, nurse anesthetists account for two-thirds of all anesthesia treatment. In a 1971 survey of hospitals, 40 percent employed only nurse anesthetists as providers of anesthesia treatment. In a 1974 study of surgical procedures, it was found that nurse anesthetists administered almost one-half of all anesthetics and that two-thirds of all anesthesia procedures in hospitals of fewer than 100 beds were administered by nurse anesthetists.

An appropriation of $3 million in 1982, for example, would provide needed traineeships of $2,000 each for about 1,500 trainees.

The total annual costs of training range from $10,000 to $15,000, up dramatically in recent years. As a result of increased costs, many smaller based programs in hospitals particularly, have been eliminated in the past few years. There are now 145 training programs nationwide, whereas there were 225 just a few years ago.

Support for traineeships would help prevent harmful attrition and at the same time stimulate the number of new training programs, thereby adding to the supply of nurse anesthetists and enhancing the quality of health care for all Americans.

I might also add that AANA endorses the views of the American Nurses Association, also represented on this panel, with respect to special projects, advanced training, and other provisions of the Nurse Training Act.

Senator INOUYE. I would like to ask you, Mr. Thomas and Professor Scott, what would be the immediate and long-term consequences if we decided not to support the nurses and permitted the shortage to increase?

Mr. THOMAS. If I may go first, Mr. Chairman, as regards nurse anesthetists in particular, the effects would probably not be as pronounced on an immediate basis as they would be, perhaps, for nurses. The reason I say this is that the traineeships program for nurse anesthetists was only authorized in 1979 by the nurse training amendments, Public Law 96–76.

The program was authorized for 1 year only, and now expired. It was not funded during the 1-year authorization. It is now under consideration by the Congress, and is going through the legislative process.

The shortage is well documented. There is a particularly acute shortage, as I mentioned, of about 7,000 to 10,000 nurse anesthetists at the present time. These figures have held rather stable since a major study assessing present and future needs was done by the Department of Health, Education, and Welfare about 5 years ago. The supply has remained relatively the same over the last 5 years.

However, we do feel that there is a particular need to provide more nurse anesthetists for the decade of the 1980's, for the demonstrable reasons discussed in our formal statement and for reasons I mentioned earlier. Therefore, we are asking for an appropriation to the extent authorized for fiscal year 1982 and beyond.

Ms. SCOTT. I would like to comment first about the requirement for nurse anesthetists. When you asked me about shortage of nurses in this country, we were relating our shortage to the patients who need care by nurses.

If you add to that the requirements for nurses to become nurse anesthetists, it only increases the shortage of nurses who provide direct patient care. So when we put together all of the requirements for nurses in this country and increasing demand, the shortage becomes much more evident.

Senator INOUYE. You were not including operating-room nurses?

Ms. SCOTT. Operating-room nurses are included in our count of nurses who work in institutions. The count of nurse anesthetists is a separate count.

So if you look at the supply of nurses in this country, there is a large supply, about 1,400,000 nurses practicing every day or close to that. However, 75 percent of them who are licensed are working in hospitals, nursing homes, public health agencies, and school health, and so on.

If there were no funds under the Nurse Training Act, obviously, the shortage would become even more acute.

In addition, patients who are now receiving care by registered nurses would not do so. We would find that the kinds of things we are trying to do to bring care to people in different settings where they can receive it more easily and at less cost would not occur.

And I would bring to your attention the efforts of nurses to have children who have cancer cared for at home, treating them out of an institution; the efforts on the part of nurses to develop childbearing centers where women can develop prenatal, delivery care, and postnatal outside of the institution, where it seems feasible to do so; care of patients with burns, and bringing them home where they can adjust better to their families and to their disabilities.

All of those things would not be available to people in this country if we continued to experience shortages of nurses. There is no doubt about that in my mind.

Senator INOUYE. Thank you very much.

Our next witness is Dr. Robert A. Mengebier.

STATEMENT OF DR. ROBERT A. MENGEBIER, BURNS CLINIC MEDICAL CENTER

Dr. MENGEBIER. That's right, sir.

First, I would like to express my appreciation for the opportunity to say a few words. I am here as an individual physician practicing in a rural area in northern lower Michigan. I am not here as a representative of organized medicine, nor am I an authority on health planning.

However, I am for continued appropriations for health planning in this country. I am concerned about what would happen if the recommendations of the administration regarding health planning are carried out—the proposal, as outlined by Mr. Stockman, which phases out total support for the entire planning program over the 1981–83 period. This policy action would supposedly be consistent with the 2-year administration timetable for development and implementation of a procompetitive bill for health financing reforms.

I'm in a group practice with 75 other specialists in a rural area. We are physically attached to a 300-bed hospital, and we're equivalent to a sophisticated medical complex in an urban center. However, the population of the community in which I live is 6,500 people. I mention that for a reason, as I'll point out in a minute. We cover practically all major specialties, and we'll have that completed within the next year.

With regard to the development of a so-called competitive system in this country, I have several problems.

In the first place, setting up and implementing such a system in a rural area would be entirely different than in an urban area. I would have to say right now, it would be impossible to do it in my area.

I think it would be very difficult to carry out such a measure effectively in a short period of time. I have heard repeatedly that it would take between 10 and 20 years for a competitive system to become established in our country.

It may be that such a system would work. I think that the mood of the country is that we would prefer that to more regulation. However, we should face up to the fact that if such a bill were passed, it would require regulation.

A greater problem is, what happens between the end of phasing out the current system and the time when the competitive system works? A voluntary system promoted by such organizations as the American Medical Association and the American Hospital Association might work, but then again, it might not. In addition, in my opinion, such a voluntary system controlled by providers would not have high credibility with the public.

I am afraid that if the current health planning system, including health systems agencies throughout this country, is dismantled, a vacuum will be caused and that in a few years surging health care costs will require Congress to once again implement regulation and control. I can see the pendulum swinging back, and the utmost degree of fear in my mind is the imposition of wage and price controls, the initiation again of discussion that the providers couldn't control their costs, so let's institute a national health care program.

I oppose centralized regulation and control. I am an advocate of local health planning. I believe that Federal and State guidelines and some funding are necessary in order to be certain that there is equity in health care throughout the country.

The mechanism which is in place today is on a local level. I believe that there have been problems with this, partially due to unrealistic expectations, in part due to Federal changes in emphasis from quality of care and accessibility to cost containment. I doubt that any organization could have been effective in cost containment in the light of inflation, improving technology, and costs related to Government involvement during the past few years.

I believe in evolutionary change and not revolutionary. I am convinced complete upheaval of our health care system into a comprehensive health care program such as Canada and the United Kingdom have would create mediocrity of care. I feel by maintaining local structuring and planning, we can avoid such a thing.

There have been complaints about the ineffectiveness in the country of health systems agencies. And it's very difficult to pin down specific examples, but they're available and can be provided for the record from agencies throughout the country.

I think one of the benefits has to do with education. By law, at least 50 percent, 51 percent of the committees and boards are composed of consumers. This has been educational for consumers, providers, and staff to work together. I would hope that such an arrangement would continue in the future.

This country is currently reevaluating the way it does business. I believe an effective partnership between business, labor, and Government is necessary for our future well-being, and that includes the health care delivery system.

Finally, I believe the best way to do the planning is locally, from the ground up. I hope we continue with interaction with Federal, State, and local levels. I urge you to consider carefully the consequences down the road if planning agencies are stamped out of existence during the next few years.

Senator INOUYE. Thank you very much, Doctor.

Although this subcommittee is not directly involved in health care delivery systems, per se, in your testimony you suggest that the Canadian system is mediocre as compared to the United States. Is that true?

Dr. MENGEBIER. In my perception, that is correct. I'm a graduate of the Canadian Medical University, and I have gone back and discussed the situation with fellow classmates and physicians.

I believe now we are still all right, on the same level in Canada, except for two things. One is loss of physicians from that country, outstanding ones. The second is curbing of finances away from one of the basic foundations of medicine, which is research. There has been a great deal of research done both in the United Kingdom and Canada, and this is no longer funded, sir.

The other thing I found there is that you don't have cost emphasis being saved. You have cost shifts. For example, before a Federal program was present in Canada, administrative costs were approximately 3 to 5 percent. The last figure that I saw was 37 percent of costs were administrative, and now those figures are no longer available to the public.

Senator INOUYE. 37 percent?

Dr. MENGEBIER. Yes.

Senator INOUYE. What would be the comparable figure in the United States?

Dr. MENGEBIER. For administration, I don't know what it is, but it's certainly increased greatly since medicare and medicaid began.

Senator INOUYE. As high as 37 percent?

Dr. MENGEBIER. I don't believe so, no.

Senator INOUYE. Your testimony has been most interesting, sir. I thank you very much.

Dr. MENGEBIER. Thank you.

Senator INOUYE. The next witness is Dr. James R. Kimmey, American Health Planning Association.

STATEMENT OF DR. JAMES R. KIMMEY, PRESIDENT, AMERICAN HEALTH PLANNING ASSOCIATION

Dr. KIMMEY. Thank you. I'm Dr. James R. Kimmey, currently the president of the American Health Planning Association, which is a national membership organization of agencies and individuals concerned with the development of a more rational health care system for the United States.

We have submitted testimony to support our findings that the administration's 1981–82 budget decisions which precipitously defund the program on the area level over 1 year and State level in 2 years will leave substantial increases for medicare and medicaid as the institutional side begins to move into massive capital expansion, without external and internal controls of competition. And we do not feel the health industry can restrain itself and keep from entering into a large capital expansion.

We included a chart following page 3 in our prepared statement that demonstrates that the increase in hospital costs alone to medicare and medicaid would pass or exceed the cost of the planning program within 2 years, even under the most conservative estimates of the new capital investment programs that might be launched by the industry.

Furthermore, nonprofit hospitals, hospitals not paid on taxes and nonprofit institutions reimbursed for the cost of capital, may find themselves in a position of being able to compete very favorably in the market process. With the Government underwriting the interest on their loans, they may compete against the profitmaking industry and possibly even impair the administration's policy for economic recovery, as funds are made available for investment and tax laws are preferentially invested in the health industry, where you can pay any rate of interest, because it's reimbursed by the reimbursement system.

We believe the health planning agencies can assist in controlling costs during the time this Congress and the health industry itself gear up for a more competitive environment, one of the justifications for the current cut. And the agencies can also provide assistance to the organizational changes necessary to create a competitive environment in the health industry.

If the administration's proposed phase-out of the 30-year planning movement is allowed to occur, we, like the previous witness, would see the probability of a strong regulatory backlash as health care costs become the principal cost leading inflation. And this may make it even more difficult to get any.

The Institute of Medicine has released a report on the experience of health planning both as a method of assuring community control of its own health future and controlling health care costs, which we would be glad to make available for the record.

The American Health Planning Association is prepared to recommend specific changes in the health planning program, to simplify its procedures and enhance its ability and assist in preparing development experiments and to broaden its base, so it's not as totally dependent on Federal money. These things can be accomplished, but not if the program is crippled in a single fiscal year and ended in two.

Senator INOUYE. We would like to receive your suggestions and proposals.

Dr. KIMMEY. Thank you.

Senator INOUYE. Our next witness is Mr. Marvin Kirby, Mid-American Health System Agency.

STATEMENT OF MARVIN L. KIRBY, PAST PRESIDENT, MID-AMERICAN HEALTH SYSTEMS AGENCY

Mr. KIRBY. I have just a brief statement. I am Marvin Kirby, the immediate past-president of the Mid-American Health Systems Agency, and a consumer representative from Kansas City, Mo.

One of the biggest benefits is the opportunity for residents of each community to have a say in decisions of how their community's health care dollars are spent. Local health agencies have attracted people from all walks of life to address health care problems. Volunteers have come to the health program for countless different reasons. The underlying motivation is often the same. They are frustrated with their current health care system and believe that by working together to get their systems together the system can be improved.

Each year the numbers of volunteers increase. The local health care systems agencies will not wipe out the regulatory role in the health care industry. The final decisions on health care facility capital expenditures will stay at the State level. The local agencies justify large expenditures. Demands for services shows that care will be offered in a high quality and cost effective manner.

Ironically, our existence is being challenged because we have not effectively controlled health care costs on a national basis. If we were designed to control costs we would have been given the powers.

We have had an impact on curbing the expansion of oversupply of services, one of the things we were designed to accomplish. We expect the hospital community to add 450 hospital beds to the Kansas City area. This will result in an annual operating cost of at least $20 million which must be paid for, from among other places, medicare and medicaid. The net result will be that the Federal health care costs, because of limits to expansion in Kansas City alone, would increase by about $8 million annually. The annual cost for the Federal budget for health planning in Kansas City has never exceeded $650,000.

HSA's have also effected changes beyond the regulatory reading. The health care plans are uneven in scope, depth and quality. They are up to each community to produce. Now we need the time and funds to put these into action. You can help by allocating sufficient funds to help this health plan.

Thank you.

Senator INOUYE. It is your concern that the cut is too severe at this time and if it were properly phased out it wouldn't be too bad?

Mr. KIRBY. My understanding is that the cut from the current budget and being completely eliminated from the following budget, is too fast. I anticipat[illegible]ealth planning can make the changes. I am not saying it should co[illegible] as it is now, but I do see the need for continued local input in th[illegible] planning system.

Senator [illegible]hank you very much.

Our nex[illegible]esents the Association for the Advancement of Health Educa[illegible]on, D[illegible]illiam M. Kane.

STATEMENT OF DR. WILLIAM M. KANE, EXECUTIVE DIRECTOR, ASSOCIATION FOR THE ADVANCEMENT OF HEALTH EDUCATION

Dr. KANE. Thank you.

I am William Kane, and I am executive director of the Association for the Advancement of Health Education. We are an individual professional membership organization which represents about 8,000 school and community health educators throughout the country.

The reason I am here today is to present to you a new concept that I would like you just to consider for the future when we are talking about health care costs, health planning, and the future of the potential that prevention has in meeting health needs of people of this country.

We recognize that we are in times of very tight economy and our professionals are among those who are losing their jobs because of proposition 13.

I do have some comments and recommendations regarding health planning and the role that a comprehensive school health education program can play in promoting the health of individuals throughout the country.

You have heard testimony today regarding alcohol and the potential that alcohol education has. You have heard testimony from people in the area of drug abuse. You have heard testimony from people in the area of family life education.

Our members are supported by the concept called comprehensive school health program. There was legislation called the Health Education Act a couple of years ago which has never been funded, which would provide assistance to local and State education agencies to develop new and strengthen existing comprehensive health education programs.

We are not going to ask for funding at this time. We realize that because of the tight situation it is virtually impossible to get new funding for new programs, but I would like to present the concept to you and the proposal and I think that it deserves consideration in the future.

One of the things that has happened as a result of Congressional interest in the potential the school has had is that 2 years ago, at the insistence of Congress, the Office of Education—then Office of Education established an office for comprehensive school health education.

That office had two major resonsibilities. One, to provide technical assistance to State and local education agencies in the area of health education and health services.

The second responsibility was to coordinate—to act as a focal point for coordinating Federal programs in the area of health and health education that impact upon kids in our local schools.

Our members feel that that office has done an excellent job in doing both—in fulfilling both of those responsibilities. We do see that there is that need at the State and local levels.

We feel that that should rightly be the responsibility and the choice of the State and local levels, but they did need technical assistance from the Department of Education.

The second thing that has created a problem is the Director of the Office of Comprehensive School Health Education was a professionally prepared individual in health education. He also was a schedule C appointment. With the new administration he did resign and his resignation was accepted and the position is currently open.

We hope there will be strong urging from both the health people and education people for some kind of a focal point which will help you people coordinate health programs and deliver them to the schools. You must remember the health sector does not have the access to the public schools. That access can only be gained through the education center and it does require close cooperation.

Thank you.

Senator INOUYE. I thank you very much, sir.

Our next witness is the executive director of public health, Mr. Michael K. Gemmell.

STATEMENT OF MICHAEL K. GEMMELL, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Mr. GEMMELL. Thank you.

In the interest of time I did have a summary statement. I would like to summarize that summary statement.

Senator INOUYE. Your full statement will be made part of the record.

Mr. GEMMELL. As you know, the Federal support to the schools of public health is the oldest health manpower training program in the country. It was passed by Congress with an intent of aiding these special, unique national resources and training men and women at the graduate level that reenter—97 percent of them do—the public service, be it State, Federal, or local or working university settings.

The intention of these programs, mainly institutional support, student support, and special project support, were geared to assisting these institutions, for the Federal Government to assist them in training men and women.

The fiscal year 1981 rescission package and the fiscal year 1982 budget, as proposed, totally eliminates this 25-year commitment, totally eliminates support for its share of training men and women for public service.

Most of the argument, Mr. Chairman, is they say that why can't our students go through the normal commercial loan market. Our students are different than the normal health professional student. They tend to be older, average age 30. They are in midcareer. In other words, they have interrupted their profession, working for, say, State or local health department, have quit their jobs and many have family obligations but have quit their jobs and gone to a school of public health for 1½ or 2 years and then reentered the public work force to implement Federal, State, and local programs.

So our students generally can't take advantage of the normal loan mechanism. Traineeship moneys allows them to go back to school for 2 years and beef up their capabilities in a very technical area of public health and then return back and serve the people.

The administration intends to phase this program down in fiscal year fiscal year 1982 to a mere token of about $500,000 to spread among 8,000 students, virtually eliminating the traineeship program. It is an attempt to eliminate the institutions support. The schools of public health have been exempted from all rescission requests for the medical and other schools for the last 2 years.

So the indication or the message from Congress in the past administrations was that schools of public health are unique in public and national resources. They deserve Federal support and cannot be considered as part of the other health professional system. But this will eliminate right away, without giving schools a chance to find alternate funding sources. The medical schools have had none now for the last 4 years. They have had time to prepare. We have not.

So we urge you and the subcommittee, if not to restore all of the funds, at least give us an opportunity to phase down the institutional support over the next 2 to 3 years so that we can find other alternative sources of funding.

That, Mr. Chairman, is a summary of our summary statement.

We urge members of the subcommittee to look very carefully at these rescissions. Mr. Chairman, we are only talking about $12 million, but this $12 million represents a very important segment of the budget and not only to the schools, there are also the students, and in 1 day a 20-year commitment, 25-year commitment is being proposed to be totally wiped out.

Thank you.

Senator INOUYE. I am acquainted with this area, and I will do what I can.

Is there any shortage of public health officers?

Mr. GEMMELL. The Surgeon General's report that came out in August 1979 stated flat out that in some key areas there are definite shortages, especially in the areas of epidemiology, biostatistics, occupational safety, and health areas and health administration.

There is a shortage of qualified health officers. There are no vacancies in those jobs because if the best qualified person cannot be found, the next one must be—you know, if a State shows vacancies, the State legislature takes those slots away so those are basically filled. But the Academy of Sciences and the report for Congress by the Health Services Administration all have indicated that there are basic needs and shortages in public health, like in nursing.

Senator INOUYE. Professor Scott and gentlemen, I thank you very much.

[The statements follow:]

STATEMENT OF JESSIE SCOTT

Mr. Chairman, we appreciate the opportunity to present our views on budget proposals.

Given the state of the national economy, there is a clear need for a thorough review of government spending programs. We understand and support that process. We hope that this review and decisions about cuts in spending will be carefully weighed at each step of the way on the basis of national priorities.

We believe that the health of the people is a priority concern, and while this does not mean that the only responsibility lies with the federal government, it is the last resort for many segments of our society which historically have not received adequate assistance from other sources.

For this reason, we disagree with the approach that would make reductions in support for programs to aid such groups as poor women and children and programs designed to sustain and improve health services. Many of these already are underfunded in terms of need. Also a matter for consideration should be the capacity of some programs to effect cost savings. Nursing maternal and child health services, for example, have resulted in reductions both in infant mortality and in the development of serious and costly health problems in infants and young children. Much of nursing research is aimed at more cost effective methods of delivery of nursing services.

We have serious concerns about the consolidation of many vital health service programs under block grants. Although some states may be able to effectively target health services to population needs, many states lack the expertise and motivation to provide for the variety of health services required by the poor and underserved populations. We view this approach as ultimately contributing to increased costs by limiting access to such services as mental health, migrant and community health, family planning, and maternal child health. It has been well documented that lack of access to these services results in higher utilization of costly acute care institutional services.

In addition to consolidation of these vital programs under block grants, the administration proposes to eliminate the clinical training supported by the programs. There is a shortage of nurses with advanced training in the areas of mental health and maternal child health. Service related research is a high priority in these maternal child health areas and cannot be accommodated in other programs. Elimination of the clinical research and training programs would seriously deplete services which even under present funding fail to meet the need.

We believe that underutilization or misutilization of registered nurses is a contributing factor both in the current nursing shortage and in the continued escalation in health care costs. To help improve this situation, federal aid to nursing education has been essential both in helping to maintain an adequate supply of nurses and in supporting opportunity for the preparation of larger numbers of nurses to assume their increasingly complex responsibilities.

It is still not clearly understood that scientific and technological advances in treatment of disease have placed a corresponding increased demand on nurses. Hospital stays are shorter, with the result that the majority of patients are sicker. Technologies used in their care are more complex. Hospital care today is often referred to as "RN intensive" because it requires the constant attention of registered nurses. In recent years the number of beds in recovery rooms, intensive care units and other specialized facilities has expanded dramatically when compared with the number of beds in general care units. In 1972, the nation had approximately 28,964 beds in intensive care units. By 1978, there were 41,115 with similar increases in other specialized areas, such as open-heart surgical facilities and cardiac intensive care units.

Despite federal assistance, which may well have staved off disaster, there are still shortages of nurses in virtually every state of the union with a particularly severe shortage of nurses prepared as clinical nurse specialists, nurse educators, nurse researchers and nursing service administrators.

Budget proposals would rescind expenditure of $63.2 million, well over half of total appropriations for the current fiscal year and would reduce 1982 appropriations from the present $106.2 million to only $15.2 million.

The withholding of already authorized funds for fiscal 1981 would have a disastrous effect on both schools and students causing discontinuation of some programs already underway.

Bills to authorize continued federal support to nursing schools and students passed both houses last year, but in the final push for adjournment conference action was not completed. The nursing legislation was part of a large health manpower bill, and there was no disagreement on the nursing provisions. We anticipate quick action on this legislation in the current session.

We would note that funding for nursing education has been cut over the years. There has been a continuing decline since 1973-74 and a reduction of nearly 15 percent since 1977. This has been reflected in admissions to schools of nursing which have been declining since 1976-77. Graduations have been dropping since 1977-78.

We would like to comment on the various categories of support for nursing education.

Nurse Practitioner

This program, for which funds were first provided in 1976, has been extremely helpful to schools in establishing and operating programs for the preparation of nurse practitioners in primary health care. It also has provided traineeships for students who reside in and agree to practice in health manpower shortage areas. This is one of only three programs under the Nurse Training Act that would receive any funding under budget proposals for fiscal 1982. We are pleased by this recognition of the need for more nurses trained to provide primary care. However, we believe the amount requested is inadequate, and it is not realistic to think these programs can flourish independently.

Special Projects

Special project funding also is recommended for the program for 1982, but at a level that would be insufficient to maintain all continuing projects or provide for new ones. This program has fostered the development of new nursing methods emphasizing primary care, health education and prevention to help meet the needs of high risk groups such as the elderly, children and pregnant women. It also provides assistance for efforts to increase the supply of nurses in underserved areas, to open opportunities in nursing for the disadvantaged, and to make available continuing education for nurses and retraining opportunities for inactive nurses wishing to return to practice. In 1980, 156 new and continuing projects were funded.

Advanced Nurse Training

This is our highest priority! As noted earlier in this testimony, there is a great shortage of nurses with advanced preparation to function in the clinical specialties and as educators and nursing service administrators. It is projected that more than 130,000 nurses with advanced education will be needed in the early 1980s. Some think that there should be at least that number today. However, there are fewer than 50,000 so prepared. Advanced training programs focus on such areas as child health, gerontology, psychiatric nursing, medical-surgical and community health nursing.

In FY 1980, 94 programs received advanced training grants. The proposed budget calls for rescissions of nearly all of current year funding, $11 out of $12 million and provides $1.3 million for 1982. This, of course, would be a crippling blow to these programs. This funding has been available only since 1976 and is only beginning to make a substantial impact on need in this area. Elimination of funds for advanced nurse training for the remainder of fiscal 1981 plus elimination of monies for traineeships to students in advanced programs will deal a serious blow to graduate nursing education.

Because of the uncertainty, 16 master's programs in the planning phase have not enrolled any students. An additional 33 grant programs with a total of 870 students enrolled also are placed in jeopardy. Some programs, particularly those recently initiated, may not survive. Enrollment in graduate programs also can be expected to decrease if there are no traineeships available to nurses wishing to obtain advanced education.

Institutional Support

Capitation grants have been available to schools to enable them to provide the staffing, facilities and other resources to carry a variety of nursing education programs. To be eligible, schools must increase enrollment or carry out two of four program options to expand and improve nursing education. Increasingly, schools have been opting to provide for clinical experience for students in community health centers, long-term care facilities and ambulatory facilities remote from the school location.

A recent survey by the Bureau of Health Professions, Health Resources Administration, shows that a high proportion of nurses trained under the disadvantaged recruitment program go on to work in inner city and rural areas thus helping alleviate the maldistribution problem.

Student Loans and Scholarships

Nursing remains one of the lowest paid professions in the country, and many nursing students come from homes with incomes that are not high enough to support any post-high school education. A survey by the National Student Nurses Association showed over 50 percent of nursing student respondents coming from homes with incomes below $15,000 per year. For the 1979-80 school year, loans went to more than 1200 schools of nursing with about 16,800 participating. Funds for that year were decreased by $9 million as a result of a rescissions with the number of students assisted decreasing by 9,500. Scholarships were provided for 8,910 students. The request for loans and scholarships consistently outstrips funds available. The NSNA survey reported that 85 percent of students receiving federal funds would be unable to continue their education without that assistance. Assistance from schools or other sources also was received by 43.52 percent of those surveyed. 61.33 percent held jobs to help meet education and maintenance costs.

Nursing student loans and scholarships are designed particularly for the disadvantaged financially distressed students, and cutbacks or elimination of funding hits hardest at minority students.

Nurse Anesthetists

The budget proposal would eliminate funding for nurse anesthetists traineeships. The program is designed to help relieve the shortage with a projected need for nurse anesthetists between 22,000 and 25,000 compared to the present supply of 15,000. More than two-thirds of nurse anesthetists are providing services in small hospitals located in medically underserved areas. They provide the bulk of anesthesia services for people in rural, sparsely populated and low-income areas. Nurse anesthetist services have been proven cost effective particularly in the 40 percent of U.S. hospitals where only nurse anesthetists are on staff and no anesthesiologists are available.

Nursing Research

Nursing research is critical if nursing costs and nursing services are to be improved. One priority of nursing research is designing and developing health care systems that are cost-effective in meeting the nursing needs of the population. It is concerned with promoting health and preventing health problems as well as decreasing negative impact of illness on patients and their families.

Although the National Academy of Sciences has given funding for nursing research a high priority since 1977 and recommended that the research capacity of nursing be increased, funding has been static since 1976. Budge proposals include no funds for nursing research in fiscal 1982. Nursing research has been supported at the very modest level of $5 million for projec grants and $1 million for research fellowships. Inflation and an increase in 1980 of the amount of each stipend have meant a decrease in the overall number of new awards that could be made for fellowships. Currently there are only 2,500 nurses prepared at the doctoral level. The estimated need is for 14,500.

In FY 1980 a total of 46 new and continuing research projects were supported with the $5 million appropriation. The projects are nursing practice oriented and address the health problems of at-risk populations such as hypertension in the Spanish-speaking population, prediction of developmental problems in children, reduction of stress in cancer therapy patients and the care and early rehabilitation of cardiac patients.

We strongly urge that nursing research funding be continued.

Mr. Chairman, we thank you for the opportunity to appear here today. We are not unwilling to take a fair share of necessary budget cuts, but we believe those proposed are excessive and will result in further nursing shortages and resultant dangers to patient care.

STATEMENT OF BURTON D. FRETZ

I am Burton D. Fretz, director of the National Senior Citizens Law Center.

The National Senior Citizens Law Center is a national support center, specializing in the legal problems of elderly poor people. We are funded by the Legal Services Corporation and the Administration on Aging of the Department of Health and Human Services. Pursuant to the Law

Center's Administration on Aging grant, we provide technical assistance to state and local offices on aging, with a view toward expanding the delivery of legal services to elderly persons. Under our Legal Services Corporation grant, our principal function is providing support services to legal services attorneys throughout the country with respect to the legal problems of elderly clients.

Many of our clients are elderly persons who have been productively and gainfully employed during their working lives, but whose advanced years have brought poverty along with a deterioration in their health. Such persons are "truly needy" and are dependent for their very survival on the programs in which cuts have been proposed.

Since the survival of a substantial number of our clients will be threatened by cuts in any one of the programs affecting the elderly, we cannot in good conscience recommend that you accept some of those proposed cuts and reject some of the others. While our testimony directs the Committee's attention to the specific impact that specific cuts will have, we feel compelled to urge you to reject all of the proposed cuts in programs that affect persons who are elderly and poor.

Health Planning

We oppose the Administration's proposal to phase out the federal health planning system over the next three years.

It is widely accepted that the unique nature of the health care marketplace insulates it from ordinary market forces. Sick people, or people with chronic conditions, do not shop around for health care. Those on limited incomes generally do not even have the choice to do so. This factor and many others make the health care sector one of the leaders of inflation. Since competition is limited, it is unlikely to have a major effect on slowing cost increases or improving quality. Thus, more, not less, needs to be done to develop HSAs and state planning authorities and to encourage full participation in them by the elderly.

In the nursing home area, where we have the most experience, HSAs have been successful in a number of undertakings related to both costs and quality control:

-- the Western Michigan HSA established "Guidelines for Review of Transfer of Nursing Homes" because of its concern, among other things, about the impact of transfer of ownership on costs to the government and to the patient;

-- the South Florida HSA's health plan suggested specific actions concerning staffing that nursing homes should implement to insure quality;

-- the Northern Virginia HSA promotes the availability and use of community-based long-term care services when appropriate and when such use will postpone placement in an institution;

-- the same HSA has used the planning process to direct prospective nursing home developers to construct facilities in underserved areas; it also encourages developers to commit themselves to serving poor people;

-- the Central Massachusetts HSA has included in its health plan and its appropriateness reviews the goal that institutionalization should occur only when care at home is not in the patient's best interest.

The health planning process encourages local citizens to be involved in the development of local services, and should be continued.

Medicaid

a. General

In proposing his budget cuts, President Reagan and the Director of the Office of Management and the Budget have promised that the "truly needy" will not bear the burden of their efforts to reduce federal spending. Yet the President has exempted the Medicare program from cuts, while proposing to cap the Medicaid program at $1 billion less than current levels. The Medicare program provides health care to the nation's elderly regardless of income. The Medicare program, however, only covers 38% of the costs of health care for the elderly. The Medicaid program is also necessary to provide health care for the low income elderly who are not covered by Medicare, and to pay the remaining costs of health care not paid for by Medicare.

The Medicaid program finances health care for the "truly needy": low-income elderly, disabled, and dependent children and their families. Twenty-one percent of the elderly in the United States receive Medicaid. It is estimated that only 39% of the elderly poor are covered by Medicaid. While the elderly constitute only 16% of the recipients of Medicaid, they account for 38% of the Medicaid budget.

Eligibility for Medicaid varies from state to state. Most states cover all recipients of Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC), which are needs-based programs with stringent income standards. Some states also cover the "medically needy" who are primarily elderly persons with severe and chronic medical needs whose incomes may be slightly above the SSI income level, but whose high medical bills are subtracted from their income to make them eligible for Medicaid.

The recent rise in Medicaid costs is primarily due to inflation, not increased use. For example, increase in costs for hospitals, nursing homes, doctors, pharmacies, and other providers account for 80% of the increase. The number of persons eligible for Medicaid has dropped by about 1.8 million since 1975 and has remained steady the past three years.

Several states over the last few years have already attempted to deal with escalating costs by reducing services. One state proposes to limit the number of covered days in the hospital to ten, a number that is below that of the average hospital stay of the elderly. For example, cancer patients require an average of 19 days in the hospital per hospitalization. Other states are proposing restricting hospital outpatient visits and emergency room visits. Still others plan to eliminate the provision of glasses, hearing aids, wheelchairs and artificial limbs. These services are vital to permit the elderly who are in poor health to live their remaining years in dignity and as much comfort as possible. Yet these cuts and more will be imposed if the President's proposal is adopted.

Other states have imposed or are planning to impose co-payments on the provision of doctor's visits or prescriptions. For a low income elderly person with a number of prescriptions, even a small co-payment can be beyond her economic grasp. Studies have shown that the imposition of even a modest co-payment results in the deterrance of early and preventive care, resulting in increased costs later for hospitalization for more severe illnesses.

b. Medicaid and Long Term Care

The only category for Medicaid services that has increased during the last few years is nursing home care. Medicaid pays for 50% of all nursing home care in the country, while Medicare only pays for 2.8%. Nursing home care is the largest single component of the Medicaid budget, consisting of 40%. In some states, it is as high as 70% of the state Medicaid budget. Nursing home care has shown an increase in utilization, in part because of an increase in the population of the elderly over age 85, and also due to an absence of alternatives to nursing homes. The National Senior Citizens Law Center supports efforts to provide alternatives to costly nursing home care which has for too long been the primary focus of our elderly health care system. However, until such alternatives are developed and adequately funded, a reduction in Medicaid will have the heaviest impact upon these most vulnerable of the elderly.

Some states are already proposing to eliminate nursing home care for the medically needy as a Medicaid benefit. Another expected result of a federal Medicaid cap would be states' eliminating optional services for people who are categorically eligible under Medicaid, including services in intermediate care facilities. If such cutbacks occurred, ICF Medicaid residents would be evicted from their facilities and would suffer physically and psychologically. As a result of transfer trauma, many would, in fact, die. In addition states would fail to realize the cost savings that elimination of the service would be expected to produce. While elimination of the ICF benefit might save states money in the short run, states would undoubtedly be forced to spend more money in the long run and they would be able to serve fewer people. Most elderly and disabled people displaced from ICF care would not go without care. They would be placed either in skilled nursing facilities (mandatory Medicaid services whose charges are higher than ICF care) or in acute care hospitals (another mandatory Medicaid service with even higher charges than SNF care). The elimination of less costly optional services may briefly postpone higher costs, but it cannot eliminate higher costs and the brief postponement occurs only at the drastic personal expense of elderly and disabled people.

c. Alternative cost containment proposals

If budget cuts must be made in the Medicaid program, the focus should be on control of hospital and nursing home rates, increased emphasis on alternatives to costly nursing home care, and more careful monitoring to assure that only necessary services are provided.

Long-term care survey and certification

The Administration proposes reducing the frequency of surveys for Medicare and Medicaid facilities and conducting surveys on a sample basis. These changes can only result in poorer quality of care in nursing homes. Nursing homes' quality can shift dramatically and rapidly with a change in administration or a new director of nursing. To assure that a facility that provided comparatively good care one month will continue to provide good care six months later after a change in administrators is to ignore experience in the long-term care field. Quality has been and remains poor in many nursing homes. Reducing governmental oversight of facilities cannot be expected to improve quality.

Social Security

a. Minimum benefit

While the Congress may feel it appropriate to make some changes here, elimination of the benefit should be rejected. Three positions have been offered to justify elimination: (1) approximately 15% of the beneficiaries are federal retirees who, by receiving this benefit are "double dipping"; (2) most of those who will be injured by elimination will be eligible for Supplemental Security Income (SSI) benefits; and (3) many of those eligible are receiving higher Social Secuirty benefits as a dependnt spouse. These arguments, whether taken separately or collectively, do not support the radical position taken by the Administration.

First, while the GAO study* indicated that federal retirees receive federal pensions averaging $900,** the GAO report reflects that at least 20% of federal retirees also receiving the minimum benefit have federal pensions of less than $500 per month. The loss of $122 per month to these individuals (and even those averaging $900) will result in substantial changes in their already meager budgets.

Second, we are troubled by the GAO's and the Administration's rationalization that if a person's income is more than the SSI monthly level (currently, $238), that person has "substantial" income. Similarly, the argument that the "truly needy" will be able to fall back upon SSI ignores how little SSI really provides, how limited an existence and how deep in poverty a person eligible for SSI is.

While there will be some for whom loss of the benefit will result in SSI eligibility, there is a large group who will not have the protection of SSI: (a) those who do not meet the categorical eligibility requirements of SSI (for example, those minimum beneficiaries aged 62 to 65, or with widows, 60 to 65); and (b) those who are so fortunate as to have a small pension (or two) which, even after the elimination of the minimum benefit, will render them ineligible for SSI. An example of the latter is an individual with a state pension of $150/month and a small private pension of $75/month. With the minimum benefit, the person receives $347/month. If he/she were to receive the amount actually due from the Social Security Administration, potentially $40.00, his/her income would be $265. He/she would not be eligible for SSI, yet his/her income would have plummeted a disastrous 23%.

Finally, 2/3 of the individuals receiving this benefit are women who, while they worked long years at low pay in the

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*"Minimum Social Security Benefit: A Windfall that Should be Eliminated," General Accounting Office, HRD-80-29, December, 1979

***Id*. p. 15.

"work force", also stayed home and worked raising their children. While it is true that some women who are entitled to the minimum benefit actually do not receive it because they receive a higher spouse's benefit, this point helps neither the Administration nor the women not receiving the spouse's benefit. If the women are already getting another, higher, social security benefit, there are no cost savings if the minimum benefit is eliminated because they were not receiving it.

Should the Congress agree to this proposed cut, it is critical to the well-being of thousands of elderly Americans that the benefit be eliminated prospectively only and, then, only for new applicants.

The Lump Sum Death Benefit

The budget revisions propose elimination of the lump sum death benefit where the worker is not survived by a spouse or minor child. While $255 is not a substantial sum, this benefit has all too often made the difference between a decent burial and potter's field. Existence of the benefit eliminates some of the elderly person's worry over how his or her body will be disposed of. It is illogical to eliminate this benefit for individuals with no one left in this world or with older children who may not be able to afford the high costs of burial or who do not care for the parent. The Administration attempts to justify this action by stating that most often the payment "go[es] directly to funeral home operators." Of course it does; they provide for the burial. If this is intended to be a penalty for funeral home operators, then rather than penalizing the worker, it would be far more useful and equitable if steps were taken to curb the excessively high costs of burial imposed upon the elderly by the funeral home industry.

c. Disability benefits

A large number of elderly people, under 65, receive disability benefits. Last year, the Congress passed the Social Security Act Amendments of 1980, P.L. 96-265, which provided, *inter alia*, for extensive revisions in the Social Security disability program, including "caps" upon the amount of benefits a disabled person is entitled to receive under the program and a variety of measures to assist disabled individuals in returning to work, without loss of much-needed medical and social services. A number of three-year demonstration projects were authorized to establish the effectiveness of these measures.

Without giving the Congress' efforts a chance to prove themselves, this Administration proposed additional cuts in the income of disabled workers, pursuant to the "mega-cap." The Congressional program, the result of a great deal of work by many people, should be allowed its three years. Constant fiddling with various aspects of the changes made last year will make it impossible to properly evaluate the program at that time.

We are also extremely concerned by the Administration's statements indicating increased zealousness in denying disability benefits. SSA's own records indicate excessively high denial rates in this program. There has been a dramatic decrease in the number of initial Disability Insurance allowances from 1971 to present. In 1971, there were 371,000 allowances and 356,000 denials at the initial stage. However, by 1979, the figures were substantially different: 295,000 allowances, 553,000 denials. (See Appendix: letter and materials from former Commissioner

Driver to Jonathan Stein.) It has been our experience that these rates reflect denials of many eligible individuals. This is an area which the Congress should seriously explore before permitting the Administration to implement a policy further encouraging denials.

Supplemental Security Income

The HHS Revised Budget indicates the Administration's intention to implement a retrospective budgeting system in SSI, rather than the current prospective system. There is no justification for this change, which will create havoc in people's lives. Under a retrospective budgeting system, a person's benefits would be based upon income and resources which he or she had at some earlier time, usually one to six months earlier, not income and resources available at the current time. It is already extremely difficult for aged, blind, and disabled people to survive on SSI. Resorting to retrospective budgeting will make it virtually impossible. Where a person had a change in income in an earlier month, there will be no way for him or her to meet expenses in the current month or future months.

Further, an individual whose resources dropped precipituously from earlier levels will not even be entitled to SSI despite the fact that he or she had exhausted all income and resources. For example, a disabled individual, unemployed due to his disability, who three months ago had $6,000 in savings and thus was ineligible for state or federal medical assistance, suffered an attack which required that he be hospitalized. Within no time, the medical costs depleted his resources, rendering him totally destitute. Despite the fact that he had no income or resources at the time he applied for SSI, this person would not be eligible for SSI for quite awhile, depending upon the number of months back HHS intends to look. As there is no emergency assistance program for people like him, the Congress should expect that he and many other aged, blind, and disabled people like him, will exist in extreme deprivation if such a system is implemented.

The justification usually offered for scrapping the prospective budgeting system is that the number of overpayments created would be reduced. However, the Congress should look carefully at the true causes of the overpayments. They most often result not because the recipient failed to report a change in income but because the information they reported to SSA was not properly utilized or simply lost. It is unconscionable to penalize the SSI recipient for the failings of the system; efforts should be made to improve the administrative system.

Conclusion

There is no doubt that the vast majority of people who will be affected by the proposed cuts in the Health and Human Services budget are the truly needy. We urge the Congress to consider carefully the severe impact of these cuts, and to vote against them.

MAR 25 1980

SEP

Mr. Jonathan M. Stein
Chief of Law Reform
Community Legal Services
Sylvania House
Locust and Juniper Streets
Philadelphia, Pennsylvania 19107

Dear Mr. Stein:

In response to your request of February 25, I am enclosing data on social security disability claims at the initial and reconsideration levels for the past 9 years.

I regret that we do not have figures on initial claims and reconsiderations for 1970 and 1972 and reconsiderations for 1971. In addition, no data for 1980 are available yet.

The officials in our Office of Hearings and Appeals have been asked to ascertain the availability of data on disability claims at appellate levels above the reconsideration level and to write to you. You should hear from them soon.

Sincerely,

William J. Driver
Commissioner of Social Security

SOCIAL SECURITY DISABILITY CLAIMS - 1971

	Initial Claims		Reconsiderations	
Region	Approvals	Denials	Approvals	Denials
Boston	21,006	14,652		
New York	50,649	42,814		
Philadelphia	41,701	37,822		
Atlanta	63,158	71,296		
Chicago	74,595	71,040		
Dallas	34,065	39,208		
Kansas City	18,644	15,422		
Denver	7,849	7,343		
San Francisco	46,799	44,932		
Seattle	12,390	11,962		
TOTAL	370,856	356,491		

SOCIAL SECURITY DISABILITY CLAIMS - 1973

Region	Initial Claims		Reconsiderations	
	Approvals	Denials	Approvals	Denials
Boston	22,086	16,955	2,899	3,955
New York	59,139	44,954	7,827	10,990
Philadelphia	47,368	46,241	7,297	12,375
Atlanta	69,249	72,893	12,890	22,160
Chicago	84,464	67,588	11,794	19,217
Dallas	35,542	42,203	7,196	13,164
Kansas City	20,059	15,372	2,322	4,077
Denver	8,191	7,604	1,149	1,916
San Francisco	48,045	47,250	6,993	13,188
Seattle	13,980	12,846	1,766	3,517
TOTAL	408,123	373,906	62,133	104,559

SOCIAL SECURITY DISABILITY CLAIMS - 1974

Region	Initial Claims		Reconsiderations	
	Approvals	Denials	Approvals	Denials
Boston	25,309	16,499	2,977	6,069
New York	64,267	39,647	7,689	13,382
Philadelphia	50,119	46,241	7,074	19,251
Atlanta	75,971	77,312	12,778	33,411
Chicago	92,096	70,333	12,581	25,257
Dallas	42,412	44,737	8,554	18,570
Kansas City	21,721	15,594	3,007	5,880
Denver	9,614	8,101	1,279	2,821
San Francisco	51,602	46,954	7,734	17,557
Seattle	15,305	10,807	2,016	4,206
TOTAL	448,416	376,225	65,689	146,404

SOCIAL SECURITY DISABILITY CLAIMS - 1975

Region	Initial Claims		Reconsiderations	
	Approvals	Denials	Approvals	Denials
Boston	24,607	20,541	3,070	5,586
New York	79,962	70,836	10,173	18,347
Philadelphia	50,870	53,230	7,370	18,230
Atlanta	85,696	102,775	14,506	38,359
Chicago	96,237	90,843	13,723	28,941
Dallas	42,234	53,724	9,063	18,625
Kansas City	21,193	18,537	3,192	5,286
Denver	9,470	9,502	1,288	2,897
San Francisco	59,848	60,563	9,732	19,522
Seattle	15,139	14,244	2,090	4,392
TOTAL	485,256	494,795	74,207	160,185

SOCIAL SECURITY DISABILITY CLAIMS - 1976

Region	Initial Claims		Reconsiderations	
	Approvals	Denials	Approvals	Denials
Boston	22,383	23,411	2,466	6,584
New York	62,082	62,038	7,677	15,902
Philadelphia	46,679	52,332	5,635	15,068
Atlanta	73,074	96,490	11,286	36,481
Chicago	83,649	90,471	10,102	25,570
Dallas	36,933	56,988	8,678	17,965
Kansas City	18,935	19,716	2,534	5,779
Denver	8,484	9,790	1,068	2,700
San Francisco	51,693	60,250	7,029	19,125
Seattle	12,807	15,668	1,622	4,738
TOTAL	416,719	487,154	58,097	149,912

SOCIAL SECURITY DISABILITY CLAIMS - 1977

	Initial Claims		Reconsiderations	
Region	Approvals	Denials	Approvals	Denials
Boston	20,769	25,588	2,542	8,886
New York	65,424	65,916	7,768	20,509
Philadelphia	38,462	56,746	4,845	21,187
Atlanta	66,282	111,452	10,700	47,718
Chicago	66,355	100,572	9,106	38,544
Dallas	33,898	61,614	6,622	22,494
Kansas City	18,385	21,180	2,491	7,550
Denver	8,471	11,150	1,163	3,740
San Francisco	35,126	66,539	5,819	24,053
Seattle	9,017	17,018	1,316	6,411
TOTAL	362,189	537,775	52,372	201,092

SOCIAL SECURITY DISABILITY CLAIMS - 1978

	Initial Claims		Reconsiderations	
Region	Approvals	Denials	Approvals	Denials
Boston	14,653	22,811	1,942	8,359
New York	35,411	63,659	5,296	23,687
Philadelphia	32,736	46,524	3,741	17,162
Atlanta	58,493	100,159	8,584	40,471
Chicago	62,818	88,389	8,655	35,049
Dallas	27,978	52,780	5,404	19,470
Kansas City	16,871	19,085	2,022	7,180
Denver	7,560	9,538	964	3,198
San Francisco	36,184	58,699	5,933	22,627
Seattle	8,854	14,983	1,289	5,596
TOTAL	301,558	476,627	43,830	182,799

SOCIAL SECURITY DISABILITY CLAIMS - 1979

Region	Initial Claims		Reconsiderations	
	Approvals	Denials	Approvals	Denials
Boston	14,973	24,652	1,753	7,307
New York	36,593	75,044	4,788	24,986
Philadelphia	36,567	59,137	3,275	17,956
Atlanta	56,314	113,246	7,345	36,008
Chicago	58,993	98,837	6,161	30,850
Dallas	25,164	66,511	3,669	21,311
Kansas City	16,446	22,263	1,544	6,036
Denver	6,667	10,525	774	3,030
San Francisco	35,030	66,123	4,312	19,253
Seattle	8,576	16,367	965	4,716
TOTAL	295,323	552,705	34,586	171,453

STATEMENT OF GORDON M. THOMAS

Mr. Chairman and members of the Subcommittee, my name is Gordon M. Thomas. I am an attorney with the law firm of White, Fine & Verville, which serves as Washington counsel to the American Association of Nurse Anesthetists, on whose behalf I am appearing today.

Mr. Chairman, AANA is pleased to have the opportunity to present testimony to you today on the budget of the Health Resources Administration of the Department of Health & Human Services. At the outset, let me emphasize that we recognize and appreciate the difficult task which this Committee and the Congress face in deciding how to appropriate our Federal tax revenues in these times of fiscal austerity and budgetary limitations. However, we feel that adequate and effective health care is and ought to be one of our highest national priorities.

With those feelings in mind, Mr. Chairman, let me move directly to a matter of particular interest and importance to AANA. In the Nurse Training Amendments of 1979, Public Law

96-76, the Congress authorized for the first time a program of grants to cover the costs of traineeships for the training of licensed, registered nurses to be nurse anesthetists. By statute, programs eligible for funding must be conducted in accredited public or private nonprofit institutions. Payments are made directly to eligible institutions and may be used only for traineeships.

Public Law 96-76 authorized $2,000,000 for nurse anesthetist traineeships for fiscal year 1980 only. That one year authorization has now expired. In the last Congress, both the Senate and the House passed comprehensive health manpower legislation which, among other things, authorized funding for nurse anesthetist traineeships for fiscal years 1981, 1982, and 1983. Unfortunately, however, the conferees on the manpower package were unable to reach final agreement on several difficult issues before sine die adjournment last year.

Mr. Chairman, earlier this month the House Energy and Commerce Subcommittee on Health and the Environment, chaired by Congressman Henry Waxman, held hearings on H.R. 2004, the Health Professions Educational Assistance and Nurse Training Amendments of 1981, also referred to as health manpower legislation. Section 307 of Chairman Waxman's bill authorizes $3,000,000 for the nurse anesthetist traineeship program for fiscal year 1982. In addition, the bill contains authorizations for a host of other vitally important health programs, many of which are now operating under a continuing appropriations resolution without specific authorizations for fiscal year 1981 and beyond. Similar legislation will be considered by the Senate Labor and Human Resources Committee next week. We are hopeful that the Congress will act expeditiously in enacting this important manpower authorization legislation.

Since funds have not previously been appropriated for the nurse anesthetist traineeship program, and since there is no current authorization for the program in effect, the Administration has not requested funds for fiscal year 1982. However, Mr. Chairman, AANA is hopeful that this Committee will include an appropriation for fiscal 1982, to the extent authorized by the health manpower legislation when enacted.

AANA is a professional organization whose membership is comprised of Certified Registered Nurse Anesthetists. There are presently about 15,000 active, practicing CRNAs in the United States. Each one of these individuals holds unique qualifications which allow him or her to administer anesthesia. For individuals to represent themselves to the public as CRNAs, they must hold a current license as a registered professional nurse, must have graduated from an accredited program of nurse anesthesia, must have passed a rigid qualifying examination, and must be involved in a program of continuing education in anesthesia.

Mr. Chairman, the CRNA is a much needed element within the health care system. To understand the type of educational program the CRNA must complete, and the type of program for which we are requesting support, it would be useful to mention the current educational requirements for CRNAs. Building on the professional nursing base, the student nurse anesthetist must complete an intensive training program which includes Orientation to Anesthesia Practice; Chemistry and Physics of Anesthesia; Advanced Anatomy, Physiology and Pathophysiology; Principles of Anesthetic Management; Pharmacology of Anesthetic, Adjunctive, and Ancillary Drugs; and Clinical Correlative Conferences. Also included in the clinical program is a requirement of a minimum of 600 hours of actual anesthesia time in which clinical instruction is provided in situations where students actually administer the anesthesia. Other requirements include a minimum of 450 cases of anesthesia actually administered, with these cases distributed according to types of techniques required and variety of drugs used. With this type of training and educational background, there should be no doubt as to the ability of the CRNA to provide the patient with quality anesthesia care.

Training programs are graduate-level programs for registered nurses. Training involves 18 to 24 consecutive months of course work and clinical instruction. A certificate of graduation is received when the program is successfully completed. All training programs are accredited by an accreditation body approved by the Department of Education. There are presently about 165 such programs, while just a few years ago there were 225.

Nationwide, nurse anesthetists are providing safe, reliable and economical anesthesia care to approximately one-half of all patients undergoing anesthesia treatment. Included in this statistic is the fact that in rural areas, nurse anesthetists account for approximately two-thirds of all anesthesia care rendered. Throughout many areas in the country, nurse anesthetists are the only providers of anesthesia care. For example, in a 1971 survey of hospitals, forty percent of all of the hospitals surveyed had only nurse anesthetists on the staff. According to figures published in the February, 1978 issue of Anesthesiology, the national mean population ratio for active, practicing nurse anesthetists is 7.20 per 100,000. This figure compares with a distribution of 4.64 anesthesiologists per 100,000. A breakdown of these figures on a regional basis shows that the areas with the thinnest distribution of anesthesiologists have the highest distribution patterns for nurse anesthetists.

Not only are CRNAs a vital segment of the health care system within the United States, but there is also a definite, projected need for more nurse anesthetists now and in the future. According to a 1976 study by the H.E.W. Bureau of Health Manpower on "Supply, Need and Distribution of Anesthesiologists and Nurse Anesthetists in the United States, 1972 and 1980" (HRA: 77-31), there was a projected need of from 22,000 to 25,000 nurse anesthetists for 1980. To be sure, there is a serious, current shortage in this field which provides approximately half of all anesthesia services in the United States. Funding of traineeships for students in schools of nurse anesthesia will be an important step in rectifying this shortage.

The fact that nurse anesthetists are a significant group in delivery of anesthesia services was pointed out graphically by Dr. Feldstein of the University of Michigan in a study of the 16,500,000 surgical procedures performed in 1974. The largest percentage of anesthetics administered, 48.5%, was rendered by CRNAs; 38.3% was rendered by anesthesiologists, including both those board-certified and non-board-certified; 9.7% by physicians other than anesthesiologists; and 3.5% by registered nurses other than CRNAs. A further breakdown of those procedures indicates that certified registered nurse anesthetists administered approximately two-thirds of all the anesthesia procedures in hospitals of fewer than 100 beds. Anesthesiologists tend to congregate in larger hospitals -- those of over 200 beds -- where they administered 47.5% of all anesthesia, compared to 42.5% for Certified Registered Nurse Anesthetists.

The majority of nurse anesthetists are salaried hospital staff, whose services are billed by the hospital as part of hospital operating room costs. According to the U.S. Department of Labor, Bureau of Labor Statistics, "Industry Wage Survey of Hospitals, August, 1975 - January, 1976", the average hourly wage for nurse anesthetists working in 21 major metropolitan areas was $8.02. Based on a 40-hour work week, the average annual earnings for a nurse anesthetist would be $16,681.60. This figure compares with full-time equivalency earnings of hospital-based anesthesiologists of $80,000 as determined by a Health Care Financing Administration "Study of the Reimbursement and Practice Arrangements of Provider-Based Physicians, December, 1977" (Contract No. 600-76-0055). An analysis of these two salary figures indicates that where nurse anesthetists are providing anesthesia services, the cost to the patient should be substantially lower than where anesthesiologists are providing the services. Even where a team approach is used, the fact that some of the time utilized is that of CRNAs, rather than that of anesthesiologists, would indicate efficiency and cost savings.

Nurse anesthetists are clearly a shortage field in health care. Possibly twice as many nurse anesthetists will be needed for the 1980s as are practicing now, according to the HEW study cited above.

One of the obstacles to satisfying the need for more nurse anesthetists is the lack of adequate financial support for trainees. Training programs are generally for two years -- a substantial graduate program. The total of tuition and related educational costs is about $10,000 for hospital-based programs and about $15,000 for most college- or university-affiliated programs per year. Tuition costs range considerably, with a few at $2,000 to $2,500 and others only nominal, with the hospital assuming all costs. Hospitals also offer stipends, but the average is about $3.000. With hospitals attempting to limit costs and with inflation unchecked, hospitals are able to devote less to these programs than in prior years. In fact, the number of hospitals offering stipends has decreased substantially in recent years due to higher costs of operation. Few offer them now. In addition, many hospitals have dropped their training programs entirely. The number of programs has decreased from 225 to 165 in recent years. Students are generally unable to hold summer or part-time jobs because the rigorous nurse anesthesia program runs for 18 to 24 consecutive months. In addition, rotating clinical schedules effectively prevent part-time work in the evenings and on weekends. These financial problems often serve to deter students from entering this important health care field. Entry level salaries are in the $15,000 range with average salaries after 5 years at $20,000. Such salary levels are not conducive to borrowing, particularly if an individual has a family to support.

To the institution, the major financial burden in training nurse anesthetists is in making stipends available to students. With living costs what they are and with no time for part-time work, increased stipends are critical. Institutions absorb $3,000 on the average toward these living and educational costs of at least $10,000. Limited resources prevent institutions from offering more aid, or from offering aid to more students. Federal support to the institutions for traineeships will allow a greater number of students to enter programs. In addition, with the Federal assumption of some traineeship costs, institutions will be able to devote a greater portion of their future resources to program expansion in other vital areas.

It should be stressed that the number of nurse anesthetist training programs has decreased in recent years by about 60. For the most part, these were the smaller-based programs. Federal support should prevent such harmful attrition and at the same time stimulate the development of new programs.

In addition, AANA endorses the views of the American Nurses Association, also represented on this panel, with respect to funding for all programs under the Nurse Training Act. In particular, we support funds for special projects, aimed at short-term program development, and for educational loans.

Mr. Chairman, we thank you and the members of the Subcommittee for your time, for your attention, and for your consideration. We are hopeful that this Committee will include an appropriation for the nurse anesthetist traineeship program to the extent authorized by health manpower legislation. We believe that revenues spent in this relatively small and inexpensive, but vital, program will greatly enhance the quality of medical care for all Americans in the years and decades to come.

STATEMENT OF DR. ROBERT A. MENGEBIER

I would first like to state that I am here as an individual physician practicing in a rural area in Northern Lower Michigan. I am not here as a representative of organized medicine nor of the organization which employs me nor as an authority on health planning. However, I am concerned about health planning.

I am a pathologist in a 75-physician multispecialty group practice in Petoskey, Michigan. My organization, the Burns Clinic, together with a physically attached, but separately organized and administered hospital, Northern Michigan Hospitals, is a medical complex providing service for approximately 16 surrounding counties including portions of the Upper Peninsula of Michigan. We are, therefore, a rural health center. All major specialties are represented except for neurosurgery which we are currently developing. I recently completed four years on the governing Board of the Burns Clinic and have been involved with many hospital matters as well. Several years ago, I was chairman of a Joint Planning Committee which required a Certificate of Need for construction and renovation of portions of the hospital and came in direct contact with our local Health Systems Agency as well as the Michigan Department of Health. In September, 1980, I was appointed by the Michigan State Medical Society to the Board of Directors of this local HSA (Northern Michigan Health Systems Agency). I am active in my local medical society chapter and on its Legislative Affairs Committee. In addition, I helped develop a committee on Government and Health Care in our Clinic and Hospital to establish and maintain communications with our legislators in Washington and Lansing and to keep our employees informed about what is happening in this area.

I am very concerned about what would happen if the recent recommendations of the Administration regarding health planning are carried out. The proposal as outlined by Budget Director Stockman would phase out federal support for the entire planning program over the 1981-1983 period. This policy action would (supposedly) be consistent with a two-year administration timetable for development and implementation of a procompetitive bill for health financing reforms.

With regard to the development of a so-called competitive system for health delivery in this country, I have several problems. In the first place, setting up and implementing such a system in a rural area would be entirely different than in an urban area. I think that it would be very difficult to carry out such a measure effectively in the geographic area in which I live. Some of our communities have no physicians, other have one or two. My community of 6,500 has ninety. How can you equate these with an urban center? Secondly, I have heard repeatedly that it would take between 10 and 20 years for a competitive system to become established in our country. It may be that such a system could work, although there is no proof of it, and it also seems probable that most of us prefer such a solution to increased government regulations of another type. I think it should be noted, however, that in a competitive system, regulation would still be required. A greater problem is what happens between the end of phasing out the current system and the time when the competitive system works? A voluntary system promoted by such organizations as the American Hospital Association and the American Medical Association might restrict costs efficiently but then again it might not. In addition, a voluntary local system controlled by providers would not, in my opinion, have high credibility with the public. I am concerned that if the recommendations of Mr. Stockman are approved and the current Health Systems Agency structure is dismantled, that within a few years, surging health care costs will require Congress to once again implement regulation and control.

I oppose centralized regulation and control. I am an advocate of local health planning. I believe that federal and state guidelines and some funding is necessary in order to be certain that there is equity of care throughout the country. There already is a mechanism in place on the local level. The Health Systems Areas and Agencies have problems, partially due, I believe, to unrealistic expectations. I think that if properly reviewed and changed, that this system would improve. The Health Systems Agencies are being blamed for their failure to contain costs. This is indeed unfortunate since emphasis on cost containment has diminished their role in considering quality of care and accessibility of service. I doubt that any organization could have been effective in cost containment in the light of inflation, improving technology and cost related government involvement.

I believe in evolutionary change not revolutionary change. I am convinced that a complete upheaval of our health care system as it currently exists into, for example, a comprehensive health care program similar to that in Canada or the United Kingdom would ultimately produce not only a financial nightmare but also mediocrity of care. I believe we are on the right track with the Health Systems Agency structure which is local but tied in to both state and federal government.

What are the benefits to date with the HSA system? I have information concerning cost curtailment in my own local region over the past few years. In addition, I think that some fundamental benefits cannot be quantitated, e.g. the educational values. By law at least 51% of the HSA boards and committees are consumers. Therefore, consumers, providers, and staff have had to work together. It has been educational and has required a great deal of patience. In many parts of this country the system has not worked in part due to the adversary position between so-called providers and consumers and staff. I believe that this is partially due to the emphasis that has been placed upon cost containment particularly by the federal and state governments with the implication that the providers are usually at fault. In my HSA there has been good cooperation and effort by all concerned. The majority of the physicians and administrators in my organization who have worked on the Board of Directors or Committees of the HSA believe that it should continue in some form. The costs of HSA's have also been criticized. I wish to point out that an overwhelming majority of the people who work within this structure are volunteers. Countless millions of dollars have been saved by their input rather than having all of this action taken by staff personnel on a full-time basis.

The HSA with which I am associated is concerned with a large geographic area of low population density. To have health care delivery methods mandated from Washington or indeed from Lansing is in my opinion a grave mistake. Unless you are on the scene you cannot appreciate the problems and variations which exist locally. In our local area we are concerned with proper planning for controlled growth of our health delivery industry as our population grows and ages. This is very different from urban areas where reductions rather than growth are the primary concern. I for one believe that continued evolution of the Health Systems Agency stucture is in the best interest of all concerned.

This country is currently re-evaluating the way it does business. I believe that an effective partnership between business, labor and government is necessary for our future well-being. I believe that this formula is necessary in the health care delivery system as well. Finally, I believe that the best way to do the planning and effectively carry it out is locally - from the ground up.

I thank you very much for giving me the opportunity of presenting my personal views in this field.

BIOGRAPHICAL SUMMARY

PERSONAL:

ROBERT A. MENGEBIER, M.D.

Born:	November 5, 1928
Citizenship:	U.S.A.
Marital Status:	Married; 3 children (adult)
Home address:	2855 Maxwell Rd., Petoskey, MI 49770

EDUCATION:

High School:	Chappaqua, New York, 1946	
Undergraduate:	Hartwick College, Oneonta, New York,	Biology, B.S., 1950
Graduate:	Boston University, Boston, MASS.	Biology, M.A., 1951
Medical:	Univ. of Western Ontario, London, Ontario, Canada	Medicine, M.D., 1958-62
	St. Joseph's Hospital, London, Ontario	Internship 1962-63
	E. W. Sparrow Hospital, Lansing, MI	Pathology Resident 1965-69
Certification:	AP/CP 1969	

EMPLOYMENT:

USAF Commissioned Officer (Clinical Chemist)	1951-58
Group Health Centre, Sault Ste. Marie, Ontario, Canada General Practice	1963-65
Burns Clinic Medical Center, P.C., Petoskey, MI Pathologist	1969-present

HOSPITAL MEDICAL STAFF AFFILIATIONS:

General Hospital, Sault Ste. Marie, Ontario	1963-65
Plummer Memorial Hospital, Sault Ste. Marie, Ontario	1963-65

Northern Michigan Hospitals, Inc., Petoskey, MI	1969-present
Charlevoix Area Hospital, Charlevoix, MI	1969-present
Community Memorial Hospital, Cheboygan, MI	1969-present

MEDICAL SOCIETIES AND ORGANIZATIONS:

American Medical Association, Michigan State Medical Society, Northern Michigan Medical Society, College of American Pathologists, American Society of Clinical Pathologists, International Academy of Pathology, Michigan Society of Pathology, American Association of Blood Banks, Michigan Association of Blood Banks, American Society of Cytology, National Association of Residents and Interns.

ADMINISTRATIVE RESPONSIBILITIES:

Vice Chief of Staff Northern Michigan Hospitals - 1976
Board of Directors, Burns Clinic Medical Center, P.C. - March 1977 - March 1981
    Vice-President - 1978
    President - 1979; 1980
Associate Medical Director, Flint Regional Red Cross - Petoskey Subcenter - 1978-present
State of Michigan Keyman, College of American Pathologists - 1980
Health Field Advisory Group of Senator Carl Levin of Michigan - 1980 to present
Board of Directors, Emmet County Red Cross - 1978-present

COMMITTEES:

Northern Michigan Hospitals: Tissue; Transfusion; Infection Control; Planning; Executive Committee; Bed Utilization; Credentials.

Burns Clinic Medical Center: Income Distribution; Planning; Audit and Accreditation; Government and Health Care.

OTHER:

Health Systems Agency Board of Directors, September 1980 - present.

STATEMENT OF DR. JAMES R. KIMMEY

I am Dr. James R. Kimmey, President of the Institute for Health Planning of Madison, Wisconsin, and currently President of the American Health Planning Association, which I am representing here today. This afternoon I will review the American Health Planning Association's perspective on the Administration's proposed FY 1981-82 budget which would end Federal support of community health planning.

The Administration's FY 1981-82 budget proposals project a rapid, one-year phase-out of Federal support of community-based, voluntary health planning, and a two-year phase-out of Federal support of State-based regulation of capital expenditures in the health care industry; thus would end a twenty-year history of Federal support for local health planning. The Administration has provided three justifications for this proposal:

1. That health planning is an inappropriate and ineffective attempt to contain health care costs;

2. That health planning is an obstacle to moving to a competitive, market-oriented health care system; and

3. That Federally-imposed health planning is an inappropriate intrusion on State and local governmental authority and prerogatives.

Underlying these stated reasons are a strongly held belief in market solutions to the problems of the health industry, a pervasive dislike of regulatory controls in a market economy, and a strong, if unstated feeling, that market economies require no external planning, but rather generate their own alternatives which are tested in the market and accepted or rejected by the consumers in that market.

These underlying premises are all valid. Market solutions would be preferable in the health sector if the necessary legislative, organizational, and attitudinal requirements for such forces to operate can be created. Regulatory controls (of the kind we now have) would be undesirable in a market economy, but even the most articulate advocates of the market solution recognize that such an economy does not now exist for health care in the United States. Market economies do not require external planning -- once markets are well established and functioning smoothly.

In serving its strongly held convictions concerning an ideal yet to be achieved, the Administration has presented specifics -- the three justifications -- which do not stand up to careful scrutiny.

Justification 1: That health planning is an inappropriate and ineffective attempt to contain health care costs.

In the current system for financing health care costs in the United States, planning and regulation are the only appropriate tools for health care cost containment. The system is organized as to place little incentive on efficiency, cost consciousness, or the public interest. Without external controls, there would be no check on institutions' natural tendencies to try to be bigger, or to provide more, than their fellow institutions. The reimbursement mechanism currently in place supports these tendencies, unconstrained by any need to meet the test of a market. Until the defects in the financing system can be remedied by appropriate Federal legislation, there is no public interest alternative to the present approach. Experience with promotion of health maintenance organizations, an organized alternative form of health care delivery, conducted under both private and Federal auspices, have shown promise. Despite both regulatory and financial incentives supporting HMOs, however, their growth has been slow, suggesting more fundamental reform of health care financing mechanisms and organization will be required if these and other alternatives to the fee-for-service system are to mature and their benefits to the public health and the public treasury are to be fully evaluated. Thus, we conclude that the planning and regulatory approach has been appropriate, and continues to be appropriate until such time as the Congress can act to change the financial incentives in the system and the system itself can act to reorganize for true competition.

If planning and regulation are appropriate to the existing system, have they been effective? Not only have they been effective, but they have been effective under very adverse circumstances. Admittedly, the effects of the current health planning and regulatory system on health care costs have been highly variable from area to area within the country. This reflects the diversity of the state programs which have been put in place and the variable maturity of such programs. It also reflects variation in support of the planning concept on the part of groups as diverse as organized medicine on the one hand and consumer activists on the other. Hospitals have had a very ambivalent attitude toward the planning program. Thus far, the most appreciative observers and participants have been the health insurance industry, major corporations, senior citizen groups, and others for whom health care is an expense item rather than an income item.

Undernourished financially, and overmanaged by a Federal government concerned almost exclusively with system costs rather than system development, the health planning system has still managed to disapprove or discourage thousands of unneeded hospital and nursing home beds, an effort that has averted unnecessary expenditures approaching $1 billion per year. A study conducted in nine states operating the full range of planning and regulatory programs envisioned by the Congress found that per capita expenditures were 5% lower in the year studied (1978) than they would have been without planning. The result was a saving of $343 million in those states alone, a figure representing two times the total national expenditure in support of the health planning program.* These studies must call into question the Administration's assumption that the health planning program is ineffective in cost containment.

Justification 2: That health planning is an obstacle to moving to a competitive, market-oriented health care system.

Interest in bringing the projected cost control and resource allocation benefits of a competitive system into the nation's health care delivery structure is gaining strength politically. It will not be an easy task. Creating the atmosphere in which competition can begin to affect supply and price for health care requires complex changes in the tax and reimbursement systems, creation of new organizational units to compete in delivering services, and changes in both physician and public attitudes concerning the best way of meeting the nation's health care needs. Moving from where we are now in the financing and organization of health services to where we must be for the market to work will take time. It has been estimated by one of the foremost proponents of the competitive solution, Dr. Alain Enthoven of Stanford University, that this process will take at least ten years before it has significant impact on health care costs. Dr. Paul Ellwood of InterStudy, another long-time advocate of competitive solutions, estimates fifteen to twenty years will be required. The major barrier to development of a competitive system is not the health planning program but rather the current tax laws and reimbursement system and the predominance of unorganized fee-for-service practice. Before competition can be expected to have an effect, the Congress must act to make the necessary changes in the tax laws and the financing system. The providers of services must act to create the organized systems of care on which every viable competitive proposal is based.

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*A list of these studies and a summary of the findings of each is appended to this testimony for your examination.

Community health planning agencies have a role in this process. It is not the role of obstruction suggested by the Administration but rather the role of assisting communities, and the providers within those communities, in making the transition from a disorganized to an organized system within which market forces will have an effect. Under Public Law 96-79, the 1979 amendments to the health planning legislation, health systems agencies became the only Federally supported entities with a clear responsibility for identifying price competitive situations in their communities and for promoting the development of competitive forces where they are absent. Planning agencies are now doing just that.

- It is the planning program, not the nation's hospitals and nursing homes, that is striving to increase price and cost consciousness about health care by publishing health facility cost and charge data.
- Planners, not their critics, continue to aggressively promote competitive alternatives to in-patient hospital and nursing home care.
- Planners, not institutional providers of care, continue to promote HMOs and other alternatives to more expensive traditional forms of care.
- Planning agencies, not medical or hospital associations, have developed directories of health care services, comparing prices, provider qualifications, and services offered.

In the absence of the community health planning structure, the process of reorganization of the delivery system and of activating consumer interests in, and understanding of, the advantages of competition, would be measurably slowed. A truly competitive market may not need external planning, but moving to a competitive market from the current disorganized approach to health care delivery is a planning challenge of the first magnitude.

Justification 3: That Federally sponsored health planning is an inappropriate intrusion on State and local governmental authority and prerogatives.

This third premise underlying the Administration's effort to eliminate the health planning program is the most difficult of all to understand on the basis of the record. The Federal government issues no certificates of need -- state governments do. The Federal government undertakes no reviews of local, institutional plans and projects -- community-based voluntary health planning agencies do. The Federal government does not decide the content and priority of state and local plans -- state and local citizens do. Perhaps no currently operating Federally funded assistance program is more clearly decentralized and more fully supportive of state and local prerogatives than the health planning program. To the extent that there is any basis for the Administration's assertion, it is that the Federal government has overmanaged the program over-standardized the plans, over-regulated the agencies, and over-defined their scope of activities.

To defund the program, as is proposed by the Administration, would indeed inappropriately intrude on state and local authority and prerogatives. Substantial loss of Federal dollars would remove the broad community input that now exists in the health care planning system. Substantial loss of Federal dollars would shift the responsibility for planning and decision making from the community at large to a limited, and often unrepresentive, subset of citizens who are in management and decision making capacities with the communities' health institutions. It would also shift total responsibility for funding local planning to these same special interests.

At the state level, the existence of Federal funding has permitted the states to conduct their planning and regulatory activities from a position of strength based on an independent community-based planning mechanism. Rapid withdrawal of federal funds would force states toward one of the greatest abuses of the public utility regulation model -- the situation in which the industry has all the data, all the talent, and "captures" the regulatory apparatus because of superior information and personnel. That would be an inappropriate intrusion in state government, not by the Federal government, but by the vested interests who are best served by maintaining the status quo.

As indicated earlier, the documented savings in nine states as a result of the operation of this program in a single year offset twice the cost of the Federal investment for the entire national program. A major beneficiary of these savings is the Federal government itself which should, and does, have a major stake in the total costs of health care through its responsibility for meeting those costs for the aged and the poor. With the phase-out of the planning and regulatory programs proposed by the Administration, the Federal government will save approximately $145 million in direct outlays per year. At the same time, the phase-out of the planning program in the absence of the financing and economic structure necessary for a price competitive environment will lead to a rapid escalation of overall costs and of the Federal share of those costs.

Consider the chart on the following page. It reflects the immediate cost consequences, for Medicare and Medicaid, of phasing out the planning program. The three estimates shown on the chart are based on different studies of the effect of planning on the growth of hospital capacity. They all reflect the enormous financial risk the Government would take by cutting out the relatively modest investment in planning.

The Administration does not acknowledge this risk, but suggests that its competition-enhancing policies will be legislatively enacted and operative within two years, negating the need for planning and regulation. Even if the legislative changes required to create a competitive mechanism can be put in place by Congress that fast, the most optimistic informed estimates suggest ten years before such changes begin to impact the cost problem. The chart suggests what will happen in the interim, between the phase-out of planning and its replacement by a competitive system.

Health institutions will be motivated to move quickly to launch projects that have been disapproved or deferred under the current planning and regulatory mechanism. The incentives for institutions to do so will not have changed as a result of repealing the health planning program. The reimbursement mechanism which provides immediate recovery of the costs of debt financing will not have been changed. Since patients, and the Federal government, underwrite institutional expense for interest on loans, shortage of capital will be no constraint. Indeed, hospitals have been considered a prime investment in the past, and since they need not be concerned with the effect of interest rates on profits, they may actually compete unfairly with other sectors of the economy for the growing investment dollars projected under other aspects of the Administration's tax program.

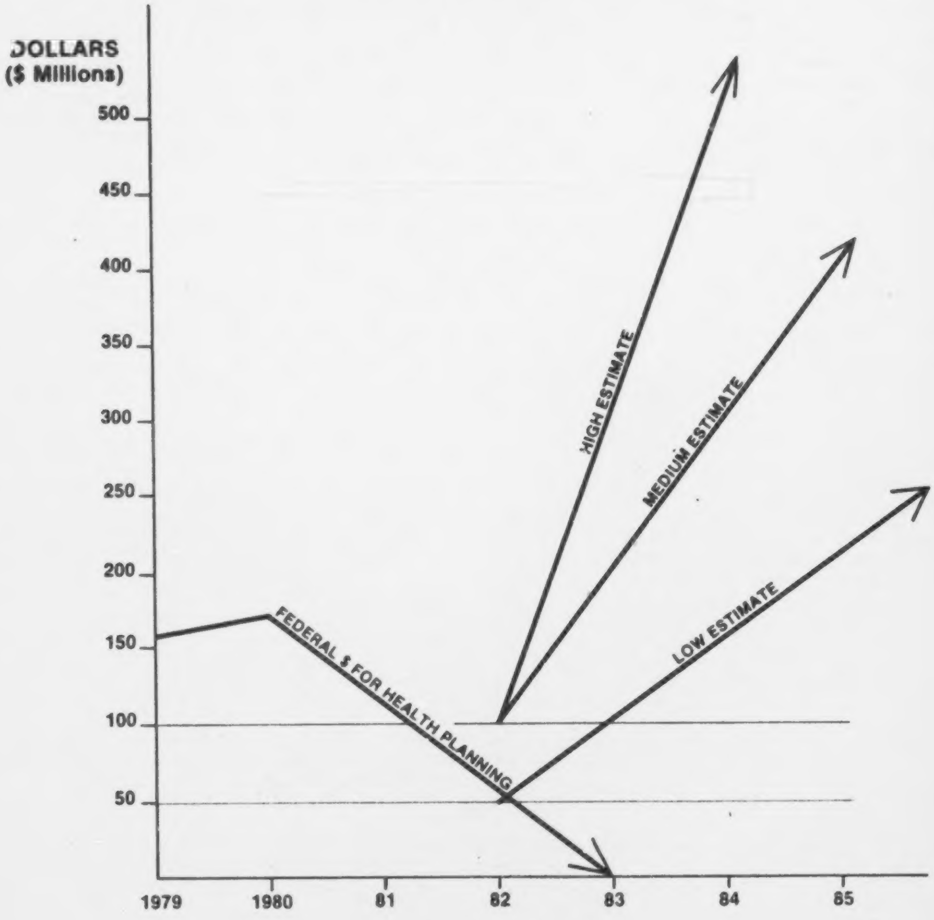
Institutions have shown little historic capacity for self restraint without the threat of external controls or the steadying influence of community opinion as reflected in the planning and review process. The Voluntary Effort on the part of the industry has failed to meet its goals. With the added incentive of the need to position the individual institution for the future competitive system, a flurry of institutional investment can be anticipated as quickly as possible following the withdrawal of Federal support of planning and regulation. Given the projected increase in physician supply, this natural tendency will be exacerbated. In considering the effect of this on the chart, remember that a capital asset generates not only the cost associated with its financing but also generates operating costs for the entire life of the asset. These operating costs, like the capital costs, are reimbursed fully by the existing reimbursement system.

It is important to point out that we are not claiming that institutions or individual providers or others currently involved in provision of health care are somehow malicious in their expenditure patterns. Rather, they are behaving precisely as one would expect them to behave given the existing economic incentives in the system. Until those incentives are changed, their behavior is predictable, as are its effects on health care costs.

The health planning program is not perfect. Like the health system itself, it must be flexible and ready to change in response to experience. Those who are engaged in the planning process from day to day as professionals or as volunteers are in the best position to identify its strengths and weaknesses, and to suggest how to enhance the former and eliminate the latter. Federal support of health planning has a twenty year history in the United States. Over that time, the health care delivery system has changed, the interests of individual institutions and the community of institutions have changed, and the Federal concerns underly-

IMPACT OF DECREASED FEDERAL FUNDING OF HEALTH PLANNING AND REGULATION ON FEDERAL HEALTH EXPENDITURES, 1981-85

Three Estimates*



*Based on studies of the effect of planning on inhibiting growth in acute-care hospital beds, these estimates reflect the impact on Medicare-Medicaid expenditures for *hospital care in new beds*, and do not consider additional expenditures caused by unnecessary modernization/renovation projects or the probable growth in nursing home beds.

ing financial support of planning have changed. The planning structure, however, has adapted successfully to each change while maintaining its community base and its voluntary nature. Health planning has shown adaptability in the past. It can adapt in the future to support a more competitive system; to shift emphasis away from regulation; and to raise more of its financial support from the communities and states that it serves. It cannot adapt, however, if it is precipitously defunded and cast aside as proposed by the Administration in the current budget.

In considering the Administration's request, you will hear many predictable reactions. Predictably, organized medicine opposes Federal financial support of health planning as unwarranted governmental intrusion in the system. Predictably, organized hospitals oppose continuation of mandatory certificate of need standards, preferring a franchising system that does not question their past actions, but assures them their share of the future market. Predictably, the Administration opposes health planning as inappropriate, anti-competitive, and excessively regulatory. Predictably, our organization supports continued Federal investment in health planning.

Perhaps less predictably, we recognize the need for, and support, changes in the program that will strengthen its function of representing community health values, while decreasing its regulatory tone. We support a full trial of the pro-competitive strategy, and believe that health planning has an important contribution to make to that trial. We support realistic efforts to broaden the financial base of health planning to more closely reflect the relative expenditures for health care in the public and private sectors. Planning by its nature, and in response to its Congressional mandate, is committed to change. We seek the opportunity to participate in an orderly transition to a more competitive system. The Administration's FY 1981-82 budget forecloses that opportunity.

SUMMARY

Our Association is not defending the status quo, either in the health system in general or in the health planning and regulatory structure as it now exists. Both must change and adapt to the economic and political realities of today, and tomorrow. We are convinced, however, that abandonment of the established system for directing development in the health system without a fully-developed competitive alternative will lead to a rapid escalation in costs, an escalation which may cause even an anti-regulatory Administration and Congress to turn to controls more stringent than anything proposed to date as preferable to the only other option -- withdrawing benefits from the elderly and the poor in order to balance the budget. If the former step is taken, the competitive approach may never get the trial it deserves. In support of this conclusion, consider the following points:

1. The Administration has erred in its estimates of the effectiveness and appropriateness of health planning in controlling costs of health care given the current system for financing and organizing such care in the United States.

2. The Administration has erred in its estimates of the time required to introduce competition into the health care sector, and of the time required for basic legislative changes to have a discernable effect on health care costs.

3. These errors compound. They will lead to a predictable and rapid inflation in health care costs as institutions respond to the existing incentives in the system which support expansionism and excess capacity.

4. Voluntary restraint on the part of the industry has failed, even under the threat of expanded direct regulation, and there is no rational basis for assuming it will work as a substitute for effective planning and regulation.

5. The presumed dampening effect of the tight capital market on institutional expansion is meaningless in the face of full reimbursement for the costs of capital.

6. The advantageous position of a largely non-profit institutional sector receiving reimbursement support for the expenses of debt financing may adversely affect the Administration's overall economic recovery policy by diverting increasing amounts of new capital into an uncontrolled health sector and away from other sectors of the economy.

7. Retention of community health planning and state health regulation will smooth the Administration's desired transition to a market economy in health by restraining cost escalation and by preparing the organizational structure needed for an adequate test of the pro-competitive model.

8. Retention of community health planning will provide a basis for promoting, coordinating and directing the non-market components of the health system -- public and voluntary health services and programs -- even when and if competition begins to exert control on the medical care component of the system.

9. As resources become more constrained, planning becomes more important. Block grants do not flow to points of need of their own initiative -- problems must be identified and priorities set with involvement of those most affected.

10. Retention of community health planning will provide the citizens of a community with a forum in which to direct the development of health services in ways most reflective of local needs and priorities, rather than totally deferring such planning and decision making to the providers' board rooms or the government's bureaucracy.

None of the benefits attributable to planning can be realized if planning is not adequately supported. The support, we believe, must come both from the federal government and from other sectors. It is equally inappropriate to ask states and communities to bear the total cost of this effort which so directly affects to federal budget, as it is to ask the federal government to bear that total cost.

APPENDIX A*

Information on Impact of Certificate-of-Need Programs

1. Data on Hospital Capital Investment and Bed Supply
2. Potential Bed Supply Expansion
3. "Regulatory Hospital Capital Investment: The Experience in Massachusetts" by J. Howell
4. Examples of local impact
5. Material from American Hospital Association survey, June 1980
6. Findings from surveys of the American Health Planning Association
7. Review of CON impact by the Health Resources Administration
8. "The Effects of Competition and Regulation of Hospital Bed Supply and the Reservation Quality of the Hospital" by P. Jaskow, August 1979
9. Comments on "Duplicating Hospital Facilities" by W. Schwartz and P. Jaskow
10. Report on "Evaluation of CON Programs" by Policy Analysis Inc., January 1981
11. "Regulatory Approaches to Hospital Cost Containment" by B. Steinwald and F. Sloan, August 1980
12. "Evaluating the Criticisms of CON" by J. Howell, January 1981
13. "Variations in Per Capita Community Hospital Expenditures" by A. Anderson
14. "Interstate Variation in CON Programs" by D. Cohodes, November 1980
15. "Report on CON Regulation of Hospitals in Massachusetts" by A. Headen, January 1981
16. "An Integrated Approach to Evaluating the Impact of Health Planning in New England" by the Codman Research Group, Inc., June 1980.

*The next four pages provide brief summaries of each of the 16 listed studies. Also appended are a summary of study #13, by Anderson, which provides the 5% figure cited on page #2 of the testimony, (see appendix C) and study #2 (potential bed supply expansion; AHPA) which provides the basis for the chart following page #4 of the testimony, (see appendix B). Any of the other material is available upon request to the AHPA.

1. - Investment and Supply Data

The amount of completed facilities construction declined in constant dollars over 30% in recent years. Bed surplus declined by about 20,000; there were declines in over half the states.

2. - Potential Bed Supply Expansion

Substantial increases in bed supply are likely in the absence of community planning activities. It is estimated at 3,000 - 16,000 beds per year. The annual Federal Government costs through Medicare and Medicaid of such additional beds will exceed the costs of the health planning program in 1-3 years.

3. Howell - Regulating Hospital Expenditures: The Experience in Massachusetts

In reviewing capital expenditures by general hospitals in Massachusetts between 1967-76, Howell identified significant modifications in project proposals due to CON review. The impact increased as the program matured. In later years, the final approved form of some projects was reduced by as much as two-thirds. There was also considerable success in preventing the duplication of high-technology equipment, specialized ancillary services and, perhaps most importantly, in changing the whole hospital investment environment.

4. Howell - Examples of local impact

Case studies of changes in project plans due to CON review are presented from three areas.

5. AHA - June, 1980 survey

Almost 20% of the hospitals with expansion plans indicated that they discontinued or postponed such plans due to CON, 1122 or other external reviews.

6. AHPA - Surveys of July, 1976 - December, 1978 and January - July 1980

Almost 20% of proposed expenditures are being denied by HSA's. In 4 states the approval rate in 1980 was less than 50%; in 16 states it was 100%. Review activities increased substantially between the two periods.

7. HRA - Review of CON impact

Examples of CON impact in Hawaii and the Northwest are reported along with data on the decline in the amount of hospital facilities construction expenditures (constant dollars) between 1972 and 1979.

8. Jaskow - The Effects of Competition and Regulation of Hospital Bed Supply and the Reservation Quality of the Hospital

As part of a study of hospital occupancy experiences, Jaskow finds that on an average, CON reduces the supply of beds 5-8%; this implies savings of at least $1 billion per year, based on 1976 data.

9. Schwartz-Jaskow Duplicated Hospital Facilities

Theoretical savings of approximately $1 billion in hospital expenditures are estimated from the application of 4 of the National Guidelines (the range is $650 million - $2 billion). However, the authors believe that indirect costs reduce or possibly eradicate this gain. HRA comments point out the analysis is incomplete, over-estimating costs and under-estimating benefits, and incorrectly assumes that demand is fixed.

10. Policy Analysis, Inc. Evaluation of the Effects of CON Programs

A nationwide study, involving quantitative data for 1968-76 and on-site interviews in 1978-79, found wide variation in the objectives and impact of state CON programs but no evidence that any of the characteristics of CON programs included in the regression analysis equations were associated with reductions in the rate of accumulation of local hospital capital stock. HRA comments point out limitations of the study, including the fact that few state programs met minimum national standards for a satisfactory program in 1976.

11. Steinwald-Sloan Regulatory Approaches to Hospital Cost Containment

Based on review of various studies, the authors conclude that emperical evidence on the effects of CON has not shown it to be effective in controlling expenditures for hospital care or costs per unit of hospital output. Evidence on compensatory and anticipatory effects from a number of studies is also outlined.

12. Howell - Evaluating the Criticism of CON

Howell notes 3 broad areas of criticism - lengthy review periods, costs of justification, and inadequate criteria and standards. She points out that operating, as well as capital costs need to be considered in calculating benefits and that community preferences, as well as institutional goals, should be considered in determing "need." At least a 5 year operating experience is required to determine ultimate outcome; evaluation is further complicated by cyclial patterns in hospital investment (about 14 years in Massachusetts).

13. Anderson - Variations in Per Capita Community Hospital Expenditures

In reviewing variations in per capita hospital expenditures by HSA in 1978, Anderson identifies an effect by "satisfactory" CON programs equal to a 5% reduction in hospital expenditures per day. CON programs are considered "satisfactory" when in compliance with the original requirements of P.L. 93-641; there were 9 such states in 1978 - he estimated effect in these 9 states is about $343 million in 1978.

14. Cohodes - Interstate Variation in CON Programs

Broad differences in 12 state CON programs are documented, based on on-site visits and analyses of specific cases.

15. Headen - Measuring the Effect of Economic Regulation: CON Regulation of Hospitals in Massachusetts, 1972-78

The study found that informal actions taken by the CON agency, which include application withdrawal, are at least as important as the formal denial of projects. When both informal and formal actions are included, there is a statistically significant reduction from these actions in the rate of hospital investment in building, equipment and sophisticated technology.

16. Codman - An Integrated Approach to Evaluating the Impact of Health Planning in New England

The study found an emphasis on health care cost regulation; the new system had been neither captured by providers nor demonstrated an effective control on institutional expansion; it depended upon the effectiveness of political bargaining. Extensive differences among local areas in expenditures, personnel and utilization are documented, along with the important impact of professional uncertainty.

APPENDIX B

Potential Expansion in Bed Supply

If the planning program is not in effect during the transition to a competitive system, there is likely to be a substantial increase or "bulge" in hospital bed expansion (as well as investments) which will have a negative impact upon Federal deficits and increase the fixed costs with which the developing competitive system will be burdened for 20 years or more. Enterprising administrators can be expected to expedite the implementation of construction plans in anticipation of potential future limits and competitive pressures. In light of current cost reimbursement practices, interest rates are not likely to be a significant deterrent.

The experiences in the mid-1970's documented the substantial increase in investments and expenditures that can occur when external constraints are removed precipitously. At the conclusion of the Economic Stabilization Program, there was an explosion of activity. The new health planning program was not prepared in most states to deal with these pressures.

A new factor in the 1980's is the increase in physician supply. Many of these new practitioners are specialists and sub-specialists with strong interests in new sophisticated technology. As they locate in new areas, they will be encouraging hospitals to purchase new, costly equipment - without regard to the availability of such equipment elsewhere in the community.

Hospitals have been interested in renovating their facilities more frequently in recent years. There are increasing tendencies to up-date or replace the plant after 15 or or so years; compared to 20-25 years in earlier periods. These pressures are likely to accelerate in the absence of community-wide planning and reviews.

Thus, it is reasonable to assume that a minimum of 3,000 additional beds per year would be added beyond what would be constructed otherwise. As indicatedin Table 1, such additional beds would increase health care costs by at least $120 million per year and Federal outlays by at least $50 million per year.

The estimate of 3,000 beds per year is based upon the American Health Planning Associations (AHPA) survey of hospital bed expansion projects from January to July of 1980 and is consistent with other information. The CON program disapproved 29% of the beds proposed, a rate of approximately 3,000 annually. The 3,000 bed estimate is the minimum number of beds which can be expected to come into the system annually if the program is removed.

A maximum estimate of 16,000 additional beds is based on Jaskow's estimate of approximately 65,000 beds kept out of the system due to the planning program's influence in restraining hospital capacity. It is not likely that the 65,000 beds would come at once but an estimate of an annual increase of 16,000 beds seems more realistic. An intermediate estimate of 8,000 additional beds per year would allow a 50% margin of error in Jaskow's estimate of program impact.

TABLE 1

ESTIMATE COST OF ADDITIONAL BEDS

Annual Increase in Beds	3,000	8,000	16,000
Projected Occupancy Rate	73%	73%	73%
Average Daily Census	2,190	5,840	11,680
Annual Patient Days	779,350	2,131,600	4,263,200
Annual Variable Costs Per Day for Increased Patient Days	$119.o (mil.)	$319.7 (mil.)	$639.5 (mil.)
Annual Federal Share (40%) of Variable Costs	$ 48.0 (mil.)	$127.0 (mil.)	$255.8 (mil.)

Table 1 indicates that the projected increased drain on the Federal budget alone ranges from $48.0 million to $255.8 million per year to operate these additional beds. These increases would be cumulative year by year. Thus, even with the minimum estimate, in about 3 years the entire planning program's budget of $150 million would be offset annually by permanent operating expenses increases in Medicare and Medicaid alone. Under mid-range assumptions, this would happen in little more than a year. Using the highest estimate, the operating costs of the expansion would be almost double the planning program's budget in just one year.

The estimate effect in Table 1 is based on the assumption that the additional operating costs would only be half of the total per diem costs. Variable costs are estimated at 50% since many of the institutional costs are fixed and will occur even in the absence of additional beds.

The estimate in Table 1 are only for additional hospital beds and do not include estimates for additional renovations, replacements, equipment, and other hospital construction as well as nursing homes and all the other elements of certificate of need coverage. If these are added, the cost to the U.S. Treasury and the public will be even greater.

Is it plausible to assume that there will be increased investments by hospitals and nursing homes?

We believe it is for the following reasons:

1. A recent survey by the American Hospital Association shows that 64% of hospitals have expansion plans for their facilities, and of those, 21% indicate they have dropped or postponed their expansion plans due to some facet of the health planning program, either the need for CON or an 1122 approval, or for planning agency approval required by Blue Cross as a condition for reimbursement of expenses.
2. Reports from local areas indicate many hospitals have institutional plans to add additional beds.
3. A prudent hospital administrator will use the hiatus between CON and a fully competitive system to ensure that the institution has the capacity and services to be fully competitive in terms of new facilities and equipment and therefore will invest as soon as possible. Such anticipatory reactions have been documented (Hellinger 1976). The industry is very sensitive to

changes in the CON program and it is highly likely they will react to its removal as they reacted to its anticipated implementation.

4. Econometric studies which indicate minimal or no effect of the planning program despite the reality of the disapproval of health care industry investments are flawed in the following ways:
   a. The studies that acknowledge restraint on certain areas of growth such as beds argue that hospitals substitute either technology or labor or other investment and, therefore, off-set any savings. However, it is just as reasonable to argue that these investments are not substitutes but are additions and without the planning program both would occur. The frequently referenced Salkever-Bice study in 1972 reported a 5% reduction in bed supply due to CON.
   b. Howell's work on Massachusetts CON demonstrates that a learning and development curve exists in the CON program. It takes time to develop criteria and standards which cover the range of CON activities, train staff and volunteers and familiarize the industry with the process. In Massachusetts, this took at least 5 years.
   c. The studies are based on 1976 data or earlier data which does not provide for enough CON programs which are fully functional and in line with any minimum standards. In addition, these studies do not differentiate adequately between effective CON programs and those which only meet legal structural requirements. Many state and local agencies have had to focus upon complying with Federal process requirements rather than substantive concerns and many are only now at the stage of developing technically effective programs. One study focused on "constraint oriented programs" (Policy Analysis Inc.) found that the average bed/population ratio in these states was held constant from 1968-76.
   d. Hospital investment has a large lag between initiation of a project and the actual placement of it on the hospital's assets. Therefore, many studies pick up hospital costs which appear during the period of CON coverage but were initiated prior to CON (grandfathering problem) and thus reduce the impact of CON.

5. More recent studies of Anderson and Jaskow have identified a substantial effect of certain CON activities.

APPENDIX C

THE EFFECTS OF CERTIFICATE OF NEED
IN STATES WHICH COMPLY WITH P.L. 93-641

The most recent and most comprehensive study of all the factors that might be associated with hospital expenditures was done by Gerard Anderson of the Department of Health and Human Services. Anderson's study explored the wide variation across the country in community hospital expenditures per capita, some areas having per capita expenditures more than three times higher than other areas. To do the analysis, Anderson looked at all the variables listed on the next page, based on 1981 data. One of the strongest, most significant relationships that emerged from Anderson's mutliple regression analyses was the effect of bed supply on admission rates and average lengths of stay. In short, the more beds there are, the more they are used and the higher the costs. One of the specific findings in this study was

> "The only regulation that appears to effect expenditures per day is Certificate of Need. An area with a satisfactory Certificate of Need program appears to reduce expenditures per day by 5.0 percent."

A "satisfactory" Certificate of Need program refers to a State and local program that is in compliance with the original requirements of Public Law 93-641. In 1978 there were nine states having such satisfactory CON programs. In 1979 there were thirty-six such states and in 1980 there were thirty-eight. Faulkner has translated the Anderson findings into costs saved in those states for the last three years.

> "1) For 1978, the overall average savings in hospital operating expenditures associated with satisfactory State CON programs was $343,247,813.
>
> 2) For 1979, the savings in hospital operating expenses amounted to $3,194,851,305.
>
> 3) For 1980, estimated savings in hospital operating expenditures associated with States with satisfactory CON programs amounted to $3,157,032,790.
>
> "Overall, then, combined total savings estimated ... over the three-year period are approximately 7.5 billion dollars."

* Obtained from "Variations in Per Capita Community Hospital Expenditures," 1978, by Gerard Anderson, Office of the Assistant Secretary for Planning and Evaluation/Health, Department of Health and Human Services.

For the complete paper, contact American Health Planning Association (202) 232-6390

February, 1981

Table 1

Variations Among Health Systems Agencies 1978

Variable	Mean	Standard Deviation	High	Low
DEPENDENT				
Expenditures Per Day.......	$173.0	$38.0	$287.0	$110.0
Admissions per 100 Persons.	18.3	2.6	25.6	12.0
Average Length of Stay.....	7.3	1.1	11.1	5.1
PATIENT SPECIFIC				
Expected Utilization Rate Per 100 Persons.........	123.4	10.3	82.4	158.0
Per Capita Income..........	4626.0	810.2	8099.0	3207.0
Percent Population Below Poverty.................	12.2	6.4	32.0	3.1
Percent No Insurance......	8.4	2.9	18.0	4.4
Median School Years Completed................	11.6	.8	13.0	9.0
Population Density Per Square Mile.............	55.2	269.3	3667.0	.07
5-Year Population Growth..	8.7%	7.4%	31.0%	-9.3%
Medicare Case Mix Index...	1549.7%	1.4	13.0%	6.9%
Percent Discharge Dead....	6.1	1.1	9.0	3.3
Infant Mortality Rate.....	1.8	.3	2.7	1.2
HEALTH CARE SYSTEM				
Bed/1000 Population.......	4.5	1.0	7.8	1.9
Nurses per 100 Beds.......	75.1	13.5	113.4	45.9
Residents per 1000 Beds...	38.0	44.0	208.9	0.0
Occupancy Rate............	71.8	6.7	88.6	54.4
ENVIRONMENTAL				
Medicaid for Medically Needy (1 - Yes, 0 - No).......	.6	.5	1.0	0.0
Hospital Wage Index.......	100.0	20.0	150.7	74.1
Blue Cross (Cost = 1, Charge = 0).............				
Satisfactory CON Program (1 - Yes, 0 - No).......	.4	.5	1.0	0.0
State Prospective Review (1 - Yes, 0 - No).......	.2	.4	1.0	0.0
Charge - Specialist Office Visit....................	10.8	2.0	19.1	6.9
Nursing Home Beds per 10,000..................	68.0	3.1	185.0	14.8
Non Community Hospitals Per Million Persons.........	5.9	3.9	25.0	0.0
HMO Enrollees Per 1000 Persons	19.0	73.4	87.8	0.0

STATEMENT OF MARVIN L. KIRBY

The Senate Labor-HHS-Education Subcommittee on Appropriations is considering, among other things, appropriations for health systems agencies (HSAs). Health systems agencies were created by P.L. 93-641, The National Health Planning and Resources Development Act of 1974.

The Administration's proposal for health systems agencies (HSAs) as outlined in the Administration's A Program for Economic Recovery, would result in HSAs being funded at greatly reduced levels for 1981 and, only money to states for the regulatory programs in 1982, thus decreasing effectiveness of local health planning immediately and eliminating HSAs entirely in 1982. The rationale offered by the Administration is that the elimination of the regulatory segment of health planning is a necessary element in the Administration's efforts to promote the effective functioning of private market forces in the health care sector.

Health systems agencies have two major functions: first and foremost is development of community-wide policies dealing with medicine and health care issues and the role of the health care system in society at large; the second and by far the least important but most visible and controversial function is quasi regulatory in nature as the HSA volunteers develop recommendations on capital projects proposed by licensed health care institutions.

HSAs perform both functions by having volunteers - providers and consumers - with the assistance of paid staff - spend thousands of hours each year becoming well informed citizens and making recommendations to community leaders concerning a wide range of local health problems, and potential solutions to those health problems.

The single greatest value of local health planning is the opportunity for local residents to have a clearly heard voice in the decision about how the community's health care dollars are spent.

Volunteers have come to the health-planning program for a variety of reasons. One HSA board member applied after his wife was hospitalized and he was dissatisfied with the system of care. Another woman applied to serve on the board because she was a devotee of health promotion programs and wanted to see more of them in the community. Another was active in senior citizens groups and wanted to make sure that the elderly were represented on the HSA board of directors.

I am a junior high school counselor, live in a rural county, have been active for five years in health planning, and came to health planning because of my interest in my community and a desire to make a contribution, no matter how small, to the quality of life in that town.

Some people volunteer because they want to keep an eye on the health-planning program, because they have a vested interest in one institution, or because they represent a geographic area that has particular health problems.

Both consumer and health care provider volunteers serve on HSA boards for good reasons and for bad, for noble purposes, and for self protection. But for the most part, they volunteer because they are frustrated with the current system and believe that by working together to coordinate services, the system can be improved.

As more people find out that the health-planning program is available to them, the number of volunteers increases. Each year the number of people applying to serve on the Mid-America Health Systems Agency Board of Directors increases. In 1980, over 50 people applied for ten positions. Some 150 people attended public hearings on the agency's 1980-1984 Health Systems Plan. Nearly 100 people volunteered last year to serve on MAHSA special committees, which develop components of the agency's health plans. Over two dozen organizations requested MAHSA speakers in 1980. Hundreds of people have called the office in response to public service announcements, newsletter articles, and advertisements. Citizens want to do something about health care, they want somewhere to turn. Health systems agencies provide a place to turn.

Local planning agencies are in the business of having volunteers work for change in the health and medical care field - changes that recognize that the leading causes of death are due to lifestyle abuses - abuses to which the present health care system only *responds* not anticipates. Almost 60% of all health care resources are spent on institutional care - not services designed to educate people about good lifestyle and what to do to achieve and maintain good health. The types of changes - social policy changes - volunteers in health planning are seeking take time to implement, but over the long run will result in a healthier population which uses the medical system in an appropriate way at a proper time at an acceptable cost.

HSAs are concerned with the cost of medical care but were not designed to control health care costs. Yet our effectiveness is being challenged because we have not proved effective in controlling costs on a national basis, and we have inhibit market forces needed to strengthen competition and provide less costly services. If we were designed to control costs then we would have been given rate review powers and the authority to control physicians and their method of practices for it is the way medicine is financed, utilized and practiced that leads to spiraling health care costs - not health planning. The rising cost of health care, which has gone up 1,500 percent in the last 25 years, has emanated from a vicious circle of market forces peculiar to the health care system, a system that does not comply with the traditional laws of supply and demand.

However, HSAs and the community have had an impact in slowing down capital expansion and the over supply (in an urban area anyway) of hospital services. Through public forums and public debate our local area has not seen approval of hospital expansions since 1976 when the old P.L. 89-749 Comprehensive Health Planning Agency expired. And yet the Kansas City metropolitan area will experience an over supply of hospital services by about 1,000 beds in 1985.

If the local health systems agency closes down and the total community voice is not heard, we fully expect the hospital community to add at least 450 licensed beds to the Kansas City community within the next four years. We estimate that will result in at least 40 million dollars of debt or an annual operating cost of at least 20 million dollars a year. That operating cost must be paid from - among other places - medicare and medicaid.

The net result will be that the federal health care costs due to unnecessary expansion in Kansas City alone will increase by about 8 million dollars annually. The annual cost to the federal budget for health planning in Kansas City - local health planning - has never exceeded $650,000.

If the Administration's budget is adopted the regulatory role of health planning will not disappear. The final decision on all capital projects has been and will stay at the state level. The only factor programmed to disappear is the opportunity for local volunteers from all walks of life to discuss in an open public forum the needs of the local community at the local level. Decisions will be made in state capitols by bureaucrats without adequate, informed volunteer input. By allowing local residents a voice in deciding how the community's health care dollars are spent, the health systems agencies ensure that providers justify large expenditures. Providers wishing to add new services or expand existing ones are sparked to answer questions beyond just the quality of their plans. They must document that there is a demand for the proposed services and that they will be offered in the most cost-effective manner. Sometimes they must compete with other facilities who have similar plans.

The health planning program has also shown consumers that they have a responsibility in the health system, and the program has offered them a forum in which to share ideas and further understand their role.

Since the inception of health systems agencies, more consumers than ever before are aware of their importance in the health care system and willing to volunteer their time to address the system's shortcomings. This has given health care providers a more acute perspective of consumers expectations.

Health systems agencies can and do provide a medium for citizens to effect positive changes beyond the regulatory arena. This has certainly been evidenced in the health plans produced by most of the HSAs across the country. These sometimes voluminous documents are custom tailored to each community, they examine the current system of health care.

The plans then outline ways to improve the current system. Many if the plans are unequalled in scope, depth. and quality, and they have provided invaluable information to health care providers and consumers in communities across the country. The plans stand as a testimony to what the residents of each community can produce, but now the communities need the time and the funds to put the plans they have developed into action.

Please give us the time to prove our worth. Allocate sufficient funds to allow a debate next year on the merits of the health planning program.

Thank you.

STATEMENT OF WILLIAM M. KANE, PH. D.

I'm William M. Kane, Ph.D., Executive Director of the Association for the Advancement of Health Education. The Association is one association of the American Alliance for Health, Physical Education, Recreation and Dance, which represents 50,000 educators throughout the country. Our member educators are committed to helping individuals improve their health through education and disease prevention programs. I am here to ask your support for five million dollars funding for P.L. 95-561, The Health Education Act of 1978. Funding for this program was not included in the President's budget request. Before discussing P.L. 95-561, I would like to provide you with a brief overview of school health education. Health education has long been recognized as an important part of elementary and secondary education. The 1918 report of the National Education Association's commission on the reorganization of education included health as one of the seven cardinal principles of education. The 1922 Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association approved a resolution to appoint a committee to prepare a program of health education for public schools. That program -- Health Education - A Program for Public Schools and Teacher Training Institutions, was published in 1924. Health Education was revised in 1930, 1941, 1948, 1961 and 1975, and continues to be the curriculum "Bible" for health education.

Today, several national health and education organizations have position statements and resolutions calling for health education in the schools. These supporters include: the American Academy of Pediatrics, the American Heart Association, the American Medical Association, the American Lung Association, the National Congress of PTA, the American Dental Association, and the Association for the Advancement of Health Education. The latter, the Association for the Advancement of Health Education, the Association which I am representing today, was the sub-structure of the National Education Association which represented NEA on the Joint NEA/AMA Committee.

The recent Surgeon General's report Healthy People called for a revolution in this nation's health strategy which would emphasize strategies for preventing the major causes of death. In background papers prepared for that report, Surgeon General Julius Richmond called for a "comprehensive national policy with respect to the health of our children -- a policy whose thrust is the enhancement of health and prevention." This emphasis on prevention was echoed by Michael McGinnis, Deputy Assistant Secretary of Health, Education and Welfare, speaking at a recent conference on child health perspectives. He stressed his belief that in the 1980's "the shift must be from curing to caring" and that greater attention to health education efforts among children and youth is an important part of this shift.

Lehmann in a paper prepared for Healthy People emphasized that "Health education in the school is especially important because both lifelong behavior patterns and development of chronic disease have their roots in childhoold." Healthy People identified the schools, which have large captive audiences, as useful centers of health education and accident prevention activities.

P.L. 95-561, the Health Education Act of 1978, demonstrates Congress' concern for the health of school aged children. This concern and the intention of Congress is reflected in the following statement from the report of the Senate Committee on Human Resources which accompanied the act:

> "The Committee believes additional emphasis must be placed on preventive health education in our public schools.
>
> Changes in personal lifestyle and a better understanding of good health principles are the key to improvements in the health of individuals and prevention of disease and illness.
>
> It is the Committee's hope that the programs under (Part I) will encourage a greater interest in providing preventive health education in our elementary and secondary schools."

Responding to Congressional concerns, the Department of Education established the Office of Comprehensive School Health. Under the capable leadership of Dr. Peter A. Cortese, a professionally prepared health educator, the Office of Comprehensive School Health did an excellent job establishing linkages with all federal programs with emphasis on the health of school aged children; and providing technical support and assistance to state and local education agencies interested in improving health education programs.

Public law 95-561, the Health Education Act of 1978, provides grants to local education agencies and state education agencies for projects that are designed to establish and support programs of comprehensive health education in elementary and secondary schools. The "comprehensiveness" of school health education is emphasized to indicate that the program includes more than single-subject "programs." However, the proposed regulations require all applicants to include in each project plan learning experiences on smoking and health. The proposed regulations also call for the applicant in its comprehensive health education program to give attention to ten other major national health concerns and to include other subjects, as appropriate.

Health education experts believe that the various subjects can be taught more effectively in a broad and integrated curriculum than in piece-meal fashion. The idea is to treat the various health-related subjects in a conceptual framework that stresses soundly-based decisions, prevention over remediation, and positive health practices in full and effective living.

One potential goal that could be accomplished under this act is in the area of leadership and coordination at the state and local level. There are currently several single-subject programs being funded by Congress which are designed to educate school aged children about health. Leadership and coordination for integrating these into local schools is desparately needed, but currently is not available. Specific example: the Bureau of Health Education recently received ten million dollars for smoking prevention education. A major target population for these smoking prevention programs was school-aged children.

During fiscal year 1980 the Department of Agriculture has twenty million dollars for nutrition education in public schools. Components of that program include nutrition education for school children and development of nutrition education curriculum materials.

The Bureau of Health Education has awarded (grants/contracts) to state departments of health to establish risk reduction programs. These programs are to be targeted to the major risks to an individual's health in each state. Many state departments of health have indicated that education programs for public school children will be a component in their programs.

Title B of the Health Services and Center Act of 1978 has 17.5 million for dealing with adolescent pregnancy has money ear-marked for education programs in pregnancy prevention. Most adolescents are in public schools. The money is currently going to family planning clinics and other service providers who develop pamphlets and posters in an unsuccessful attempt to fulfill the education/prevention requirements of the mandate.

In addition to Congressionally mandated programs, the American Lung Association, the American Heart Association, the American Dental Association, the American Dairy Council, the American Cancer Society, Avon, Weight Watchers International, and a host of other organizations are developing special interest health education materials and curriculums for kids in schools.

State directors of health education, those responsible to state superintendents of public instruction, and professionally prepared school health educators, have been overwhelmed and are critical of the problems this disorganized approach has caused, These people have been inundated with the special interest group requests -

all with good intentions - seeking access to kids through school programs. Many of these health education units and materials prepared outside the schools by special interest groups are not readily adaptable to school curriculum and structure. Schools need help to establish linkages, with health education projects currently designed to serve students; modify health education programs developed outside the school for use in the school; assist groups without expertise in school health education to tailor programs to school-age children's needs; and to coordinate and integrate existing health education components into a comprehensive program which will insure the individual components will achieve the intended effects. In short, ways to link the health education funds with the target group -- kids -- must be found. The overall objectives of each of these single-subject components can be more effectively realized in schools if the individual components can be integrated into a comprehensive, sequential program that can impact on kids.

A model to do that is only one of the potential products funding this amendment would encourage.

The proposed regulations governing the administration of grants under P.L. 95-561 suggest the funds be available for comprehensive school health education projects that --

"(A) Contribute to the advancement of a coordinated school health program.

(B) Identify and demonstrate effective methods, materials, practices, organizational patterns, and administrative procedures that develop or strengthen the comprehensive school health education program; and

(C) Develop or strengthen a comprehensive school health curriculum, that --

(1) Includes learning experiences for smoking and health;

(2) Addresses the following major national health concerns by providing learning experiences either in the project or in other aspects of its comprehensive school health education program:

- (a) nutrition and food.
- (b) values of exercise.
- (c) weight control and obesity.
- (d) immunization.
- (e) mental health.
- (f) medical, dental and other health care.
- (g) consumer health interests.
- (h) environmental conditions effecting health.
- (i) alcohol and drug abuse.
- (j) safety and accident prevention.

(3) Provides learning experiences also, as appropriate, on -

- (a) community health;
- (b) dental health and oral hygiene;
- (c) chronic disease-risk factors and prevention;
- (d) communicable disease-prevention and control;
- (e) family life education;
- (f) first aid and cardio-pulmonary resuscitation;
- (g) health careers;
- (h) personal grooming and body care;
- (i) physical fitness;
- (j) sleep, rest, and relaxation; and
- (k) work and recreation;

(4) Selects and organizes these learning experiences in a progressive sequence according to the assessed needs, interests, developmental level, and previous experiences of students."

Five million dollars funding would allow the Department of Education to award grants to thirty local education agencies averaging approximately $75,000 and to fifteen state education agencies averaging $150,000. The proposed regulations would require the agencies to develop strategies that contribute to the advancement of the coordinated state or local school health program.

This small amount of money will at last establish within the Department of Education a program component responsible for the health of school children.

Health education has the potential to extend the number of years an individual will live, and to improve the quality of each day lived. One of America's most cherished dreams is that each child will have the opportunity to develop to the fullest of his or her potential. Funding P.L. 95-561 will be a giant step toward helping children achieve that goal.

STATEMENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

The Association of Schools of Public Health (ASPH)*, which represents all of the twenty-one U.S. Schools of Public Health, appreciates this opportunity to present its views on the FY1982 appropriations bill.

The purpose of this statement is two-fold: one is to make the Congress and this Subcommittee aware of the major training and financial problems facing Schools of Public Health today;

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*ASPH is the only national organization representing the Deans, faculty and students of the twenty-one Schools of Public Health. The Schools represent the primary educational system that trains personnel needed to operate our Nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel.

and two is to clearly spell out the ASPH position on the federal role in public health professional educational assistance programs.

Public health deals with the protection and improvement of community health by organized community effort. Public health activities are essentially a public or government responsibility. The services of public health agencies are not reimbursable on a fee-for-service basis as are personal health services. Rather than treating the symptoms of disease in one person, public health is concerned with discovering how a disease occurs, in halting its spread and in organizing programs for those who have been or may be affected by it in a community, state or nation. The goal in theory and in practice is to discover the source of ill health and to reduce or eliminate it at the earliest point. As a public responsibility such preventive activities have been largely supported by public funds.

Public health measures have been successful in controlling communicable diseases as a major cause of death in the United States. While these measures should continue to prevent a resurgence, today the major public health problems in this country involve the causes and control of chronic diseases such as cancer and heart disease; the control or elimination of environmental health hazards; and the provision of equal access to quality health care at reasonable costs.

In recent years Congress has addressed these problems through significant legislation dealing with environmental health, disease prevention and planning, evaluation and management of the health care delivery system. Such legislation has created growing manpower needs in public health. The demand is expected to continue and increase as new programs to improve the quality of life and reduce health care costs are enacted, yet Federal support has actually declined since the mid-1960's (See Table I and Attachment A).

Few studies have been conducted on the impact of the new legislative initiatives on the demand for public health manpower. A study conducted in 1973, prior to the enactment of the health planning law and the current emphasis on cost containment, showed a short fall in every category of professional public health manpower:

U.S. ESTIMATED SUPPLY OF AND REQUIREMENTS FOR SELECTED CATEGORIES
OF PROFESSIONAL AND PUBLIC HEALTH MANPOWER*

	Professionals with masters level training or higher			
		1980 Supply, assuming		
Occupational Category	Base Year Supply (1970 unless specified)	Constant School Output	Reduced School Output	Possible 1980's Requirements
Environmental Health	2,200	4,300	3,800	5,000
Epidemiology	1,000	1,800	1,500	2,000
Health Education	2,000	3,600	3,100	6,000
Health Services Administration	8,500	18,200	15,300	25,200
Health Statistics	1,100	1,700	1,500	2,500
Maternal Health, Family Planning & Child Health	800	1,800	1,500	2,000
Mental Health	200	400	350	1,100
Public Health Dentistry	300	550	500	550
Public Health Nursing	2,457	5,200	4,500	5,700
Public Health Nutrition	1,000	1,800	1,500	2,600
Public Health Veterinary Medicine	200	350	300	550

* Department of Health Administration, School of Public Health, University of North Carolina. Professional Health Manpower for Community Health Programs. Chapel Hill, North Carolina, 1973.

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The Schools of Public Health are the major manpower training resources available to meet the increasing demand for highly trained and competent personnel in the public health field.

Federal health professional manpower policy has focused almost exclusively on physicians and has based policy decisions affecting other health professions on conclusions relating to physicians. For example, studies have shown that there may be a substantial oversupply of physicians around 1990. Based on this finding the President's FY 1982 budget request assumes an oversupply of all health professionals and consequently targets its request for health professions education programs at minimizing the future oversupply of health professionals. As suggested by the chart, the available evidence indicates an undersupply of public heatlh personnel. Also the recent Surgeon General's report (Healthy People) found that there is a need for prevention manpower especially in the fields of epidemiology, biostatistics, health administration, environmental health, occupational safety and health, nutrition, among others. Further, a December 1979 HHS report to Congress on community and public health personnel also called for increased federal support to programs training professionals in these priority public health areas.

The Schools of Public Health* have been educating professionals in the techniques of public health practice, health preservation, health promotion and disease prevention and control since the first decades of the twentieth century. Some Schools of Public Health had their beginnings in university schools of medicine; others were conceived from the outset as autonomous units within their parent institutions. Today there are twenty-one fully accredited Schools of Public Health in the United States, 7 at private and 14 at public universities.

Schools of Public Health are distinct from other health professions schools in a number of ways. They are oriented to the community and prevention rather than to the individual and cure. They train people in a value system that is equalitarian and public service oriented. They train persons to be need oriented rather than demand oriented. They teach techniques of need response and how to view the "community as a patient". Students are prepared for community teamwork and administration rather than private practice. To solve community health problems the typical graduate works on a team in organized community action, deals with administrative problems and must understand group behavior as well as health care techniques.

Located in 17 states and Puerto Rico, the 21 accredited Schools of Public Health train students from every state in the nation. The Schools have a combined enrollment of over 7,000 students and a faculty in excess of 1,700.** Graduate education in the 21 Schools is organized around a number of major specialties. Some of the fields of concentration offered by the Schools are:

Behavioral and Social Sciences
Biostatistics
Environmental Health Sciences
Epidemiology
Health Services Administration,
 Policy & Management
Health Education
International Health
Maternal & Child Health
Nutrition
Occupational Health & Safety
Population Studies
Public Health Practice & Program
 Management (e.g., public health nursing)

Graduates of the Schools of Public Health work primarily in the public sector in the areas of health promotion and disease prevention. They represent the basic resource pool from which Federal, state and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings. Industry relies heavily on the Schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others. The breakdown is as follows: 50 percent of graduates in a single given year go into federal, state or local government service, 34 percent work for either non-profit community health agencies or universities and 4 percent work for industry.

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*University of Alabama in Birmingham, University of California-Berkeley, University of California-Los Angeles, Columbia University, Harvard University, University of Hawaii, University of Illinois, The Johns Hopkins University, University of Loma Linda, University of Massachusetts, University of Michigan, University of Minnesota, University of North Carolina, University of Oklahoma, University of Pittsburgh, University of Puerto Rico, University of South Carolina, University of Texas at Houston, Tulane University, University of Washington and Yale University. Boston University and San Diego State University will be seeking accreditation in the Fall of 1981 and 1982, respectively.

**When Federal support for Schools of Public Health began in the late 1950s, 11 Schools were training 2,000 students. Federal support has remained constant since the early 1970s. In constant dollars, Federal support has declined drastically (See Table I and Attachment A).

ASPH data shows that the Schools no longer primarily train professionals for state and local government agencies. In response to a demand for new types of health workers and a broader concept of public health, the Schools have made major efforts to train students in health services administration and epidemiology, now the two most frequently chosen areas of specialization. Health services administration attracted 1,923 students in 1979-80, or 26.1 percent of the total. With health planning and policy studies counted in, that total would be even higher. Epidemiology narrowly displaced environmental health/sciences as the second most frequently chosen specialty. Environmental health/sciences ranked third with 900 students in 1979-80 (12.2 percent), while "other"areas of specialization was fourth with 827 students (11.2 percent) and public health practice and program management ranked fifth with 651 students (8.8 percent).

Students who attend the Schools are often mid-career professionals with a prior commitment to public service. The average age is slightly over 30. A large percentage are part-time students already working in the public sector while upgrading their skills. It should be noted that a public health degree does not increase the income potential of the graduate as much as other health professions degrees. Schools of Public Health are in the business of training men and women for public service.

The 21 accredited Schools are two-thirds state owned and one-third privately owned. In FY 1974, less than one percent (0.9) of total state expenditures for support of health manpower training institutions went to public health. The lion's share (64.5 percent) went to the training of phsyicians. None of the private institutions, except the University of Pittsburgh, receives state support. Private Schools by and large depend on the traditional means of private sector support such as endowments, tuition, gifts, etc., yet they are in the business of training workers for the public sector.

FEDERAL ASSISTANCE TO SCHOOLS OF PUBLIC HEALTH

I. Institutional Support (Section 770(a)(2) of P.L. 94-484)

Federal assistance to encourage development of experienced public health professionals began with traineeship support in 1956, thus making federal aid to Schools of Public Health one of the oldest health manpower training programs. Federal institutional support was authorized in 1958 and the special project grants program began in 1960. Since the federal assistance program began, the number of accredited Schools has almost doubled from 11 to 21 and the enrollment has increased fivefold, yet Federal support has remained constant since 1975. In current dollars, institutional support has declined more than 40 percent since 1970 (See Table II).

The basic intention of Federal institutional support to public health schools is to increase the supply of health manpower in fields where the demand is high and/or where a shortage exists. The July 1979 Surgeon General's Report said that although there is a lack of public health manpower data,* there are definite shortages of certain specialized disciplines such as epidemiologists, biostatisticians, occupational and environmental health workers and health service administrators. The overwhelming majority of these professionals are trained in Schools of Public Health.

Institutional support to both public and private non-profit Schools has provided a general subsidy which may be used for any educational program of the Schools including teaching and community service. Such grants supplement other sources of income and permit a degree of flexibility in program development. For the newer and smaller Schools the institutional subsidy has stimulated growth and provides a measure of financial stability.

Providing basic institutional support is a means whereby the Federal government can share the costs** with states and private institutions for the training of public health personnel to manage and operate governmental health programs.

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*Reasons for the lack of data are several, such as lack of uniform and fixed definitions and requirements for employment, methodological problems and high costs of gathering information.

**Teaching costs per student per year approximate those of medical schools. ASPH estimates that it costs $10,000 to train one public health student each year.

The Schools still need flexible but accountable funds which they can use to support parts of their overall program which have been weakened by insufficient Federal, state and local and private financing.

Adequate training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment. However, there are no categorical funds available, except the old formula grants and the present capitation grants, that provide adequate support for curriculum development and program support.

ASPH believes that Congress should provide the basic generic support for improving the quality of the curriculum and teach techniques and enhance the capacity of the Schools to provide health promotion and disease prevention activities in the community.

An alternative to capitation is needed because of the general disfavor of the program. While it has been effective in increasing enrollment, it has not been effective as a means of addressing the problems of specialty and geographic maldistribution. Dealing with these problems requires targeted programs of assistance. Basic institutional support would assure the health care system an adequate supply of public health professionals in defined national priority areas. HR 2004 targets financial support to categorical programs that are responsive to national health requirements and programs. The quid pro quo implied in Federal support is based on results in terms of increased minority enrollments, public service commitment of students and graduates attracted to specialty and geographic areas in need. Federal support, in terms of instituitonal, student, and curriculum assistance, challenges Schools to place emphasis on Federally defined priority areas. It ensures the training of professionals (such as health administrators, biostatisticians, epidemiologists, public health nurses, preventive medicine specialists, environmental and occupational health specialists, nutritionists, maternal and child health workers, among others) who would provide services in disease control, protection against health hazards, health services management, reduction of cost, health promotion as well as disease prevention.

The Administration has proposed the termination of capitation funds for all health professions schools in FY 1982 based on the assumption that capitation grants are incentive payments to Schools to increase their enrollment and are no longer needed since there is or will be an adequate supply of licensed health professionals in the 1980s and 1990s. Yet ASPH studies and two prepared by HHS* point out that the demand for the types of health manpower trained by Schools of Public Health will increase as a result of current and future legislative and Administration initiatives in the fields of disease prevention and health promotion (not to mention improved management of health services delivery). These initiatives are looked upon as means to improve the quality of life and to reduce skyrocketing health care costs.

In view of the growing demand for health manpower stimulated by recent passage of Federal programs such as health planning, clean air, clean water, toxic substances, health maintenance organizations, older Americans act, nutrition programs, PSROs, and other federal initiatives such as home health care, child immunizations, mental health, child health, health promotion, rural and urban health initiatives, among others, the ASPH believes that continued institutional support is justified by the nature of public health as a governmental enterprise aimed at the improvement of the public's health. Furthermore, the Schools of Public Health presently represent the major source of supply of trained personnel to implement and manage the Federal health programs and initiatives. Institutional support is simply a partial reimbursement of costs incurred by the Schools in providing comprehensive training of personnel for Federal, state and local governments, industry and voluntary health agencies charged with the responsibility of carrying out Federal programs and meeting Federal health requirements.

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*A December 1979 report to Congress on Community and Public Health Personnel and the Surgeon General's Report, Healthy People. Also the Institute of Medicine and NIH have repeatedly stated that a short supply of epidemiologists and biostatisticians exists.

**The Administration also has requested Congress to rescind FY1981 funds for institutional and student support to Schools of Public Health.

In terms of percentage that institutional support would represent as part of the federal health budget, the figure ($8 million) is miniscule. When one examines the percentage these grants will represent in the total operating funds of Schools of Public Health, however, the percentage will be around 10 percent.

The Federal funds received by Schools of Public Health have been considered to be the Federal government's share of preparing public health personnel to meet the needs of the public today and for the future. The amounts, while small in comparison to overall expenditures, have and will continue to contribute to the preparation of this vital health resource.

The capacity of the Schools to respond to emerging needs, to offer a balanced curriculum and to provide graduate training in critical areas which are unsupported by other funding sources would be severely reduced by the absence of institutional support. To delete institutional support now or in the near future will diminish the ability of the Schools to serve the Nation's health in the manner intended by these national leaders who first conceived the notion of financial support to Schools of Public Health.

The justification for continuing institutional support to students and Schools of Public Health is generally the same as it was 20 years ago when the program first began. Public health schools train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH urges the Committee to approve $8 million in FY1982 funds for institutional support grants to Schools of Public Health. The new amount represents a $1.5 million increase over FY1981. This, in turn, would provide approximately $1,000 each to 7,900 students, although it costs approximately $10,00 a year to train one MPH student.

II. Student Assistance (Traineeships or Section 748 of P.L. 94-484)

This program provides needed support to students entering or continuing their professional careers in public health.

When the "Health Professions Educational Assistance Act of 1976" was originally passed, Section 748 authorized traineeships for Schools of Public Health alone. Subsequently, it was discovered that preventive medicine and dentistry residencies had been overlooked in drafting the Act. This section was then amended to cover them and to include other public or non-profit institutions providing graduate training in public health. The authorization level was raised $1 million for each of the years of authorization to accommodate the expanded eligibility. However, these extra funds have never been appropriated. Yet there is a great demand for physicians in preventive medicine (See Attachment C).

it was discovered that preventive medicine and dentistry residencies had been overlooked in drafting the Act. This section was then amended to cover them and to include other public or non-profit institutions providing graduate training in public health. The authorization level was raised $1 million for each of the years of authorization to accommodate the expanded eligibility. However, these funds have never been appropriated.
For this reason, we strongly support passage of the preventive medicine Section 794(D) of H.R. 2004.

The traineeship program is intended to attract high caliber students and to offer the economically disadvantaged, especially minorities, an entry point into the system. The rising cost of tuition and other expenses will make it even more difficult for low-income students, particuarly minorities, to afford graduate education in public health schools. Furthermore, many undertake graduate study in public health at mid-career and have important family obligations. Others have already accrued heavy debts from their previous education. Over 75 percent of students received some form of financial help in 1979-80.

The graduates, unlike many of the other health professions, do not enjoy lucrative incomes. Over 90 percent of the graduates are employed by governmental and community agencies and universities. Their modest salary levels are reflected in a recent survey which showed an average of only $30,000 after 15 years of experience. Of the 1979 graduates, 57 percent earn less than $19,000 per year, 17 percent $19,000 to $22,000, and 20 percent $25,000.

Calculated in constant dollars, traineeship support has declined by 48.6 percent since 1970 with enrollments growing in that same period (52 percent). This has meant less money to be spread among more students. (See Table III).

It should be noted that the limitation on the amount of an individual traineeship award puts the Schools of Public Health at a competitive disadvantage in recruiting physician students in residency programs.

Traineeship support to students in Schools of Public Health is justified on the grounds that a majority of our students enter (or re-enter) public service. A recent ASPH survey* of 1979 graduates shows that 50 percent worked in tax supported agencies of the Federal, state, regional and local governments and 26 percent worked for voluntary and non-profit, private health organizations. Over 32 percent of the 1979 graduates are providing public service administrative, planning or evaluation services, 15 percent education or other training services in public health, 5 percent public health community organizational services and 38 percent are providing technical services such as clinical, laboratory, social and environmental services.

ASPH urges the Committee to recommend the appropriation of $8 million in FY1982 funds for traineeships. Again, Mr. Chairman, Schools of Public Health train men and women** primarily for service in the public sector in the areas of health promotion, disease prevention and in the organization and administration of health services. Traineeships support these individuals in their public service career paths. This $1 million increase over FY1981 would only partially recover the 50 percent loss the program has suffered since 1970 in current dollars (See Table III).

III. Special Projects (Section 792 of P.L. 94-484).

ASPH requests $6 million in FY1982 funds for special projects grants. This section goes further in greatly re-gaining the losses to the Schools brought on by inflation. As inflation has gone up, Federal assistance in special project grants has gone down. in FY 1973, the Congress appropriated $6 million for special projects; in Fy 1981 it approved $5 million which represents $3.0 million in 1972 dollars. Yet School enrollment increased 40 percent since 1973. (See Table IV).

These grants are used for projects that are designed to place emphasis on curriculum in the areas of national public health manpower needs (epidemiology, biostatistics, health administration, nutrition, gerontology, environmental and occupational health, maternal and child health, among others). These grants are used to complement Federal initiatives that are stimulating a growing demand for public health personnel.

The special project grants program began in 1960 and was intended to aid accredited Schools of Public Health to develop new programs and expand existing programs in biostatistics and epidemiology, health administration, health planning, health policy analysis and planning, environmental and occupational health and dietetics and nutrition. An amendment by the 95th Congress opened this authority to any educational entity offering programs in the above areas without increasing the authorization level.

Project grants provide support for the development of training opportunities in public health to meet emerging national priorities for public health manpower competencies. These include the training of leadership for management and specialized responsibilities in new and projected health agencies such as HMOs, PSROs, HSAs and agencies to control environmental health hazards, plus private industry.

Project grant appropriations have been decreasing since 1973. Inflationary pressures have accelerated that decline. Calculated in constant dollars in the FY1981 appropriation of $5 million is 40 percent less than the amount appropriated in FY 1973.(See Table IV).

Further, Schools of Public Health do not receive all of the money appropriated. As a competitive program, Schools of Public Health must now compete with all programs in health administration, environmental health, nutrition and other educational entities offering training in the specified fields. However, we support Federal assistance to these programs since they greatly contribute to the needed public health manpower pool.

ASPH joins the Association of University Programs in Health Administration in supporting the increased appropriation levels for special project grants to Schools of Public Health and graduate programs in health administration. Here is the justification. Training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment.

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*Survey and analysis by Thomas Hall, M.D., of the School of Public Health at the University of North Carolina. (See Attachment B).

**In 1979-80, 53.6 percent of public health students were women.

ASPH urges the Committe to recommend the appropriation of $6 million in FY1982 funds for special projects authorized under P.L. 94-484 (Section 792). These funds will provide support for curriculum development that will enable the Schools to stay current with technological and scientific advances in public health and medical fields. ASPH believes that increases for special project grants would provide the basic generic support for improving the quality of the curriculum and teaching techniques and enhance the capacity of the Schools and health administration programs to provide health promotion and disease prevention as well as health services management activities in the community, state and Nation.

This $1 million increase over FY1981 would only partially recover losses brought on by inflation to this program (See Table IV).

IV Summary

ASPH respectfully requests the following FY1982 appropriations for programs of concern to Schools of Public Health:

	Final FY1981 Approp.	FY1980 Auth.	FY1982 Pres. Request	FY1982 ASPH Request
Institutional Support (Sec. 770)	6.5	11.0	0.0	8.0
Special Projects (Sec. 792)	5.0	6.0	6.0	6.0
Traineeships (Sec. 748)	7.0	10.0	0.0	8.0
Total	18.5	27.0	6.0	22.0

ASPH believes that the $22 million in FY1982 funds requested for Schools of Public Health is only a small token of federal support to a manpower production system that trains health professionals for public service. Those funds can greatly contribute to the recommendations contained in the 1979 Surgeon General's report Healthy People:

> It is the thesis of this report that further improvements in the health of the American people can and will be achieved -- not alone through increased medical care and greater health expenditures -- but through a renewed national commitment to efforts designed to prevent disease and to promote health.
>
> AND
>
> In the field of public health, in contrast to personal health, manpower shortages are believed to exist in some key fields, including occupational health, epidemiology, biostatistics, and health services administration.

In summary, the ASPH believes that continued Federal assistance is actually an investment at the front end of the health care system. The Schools (i.e., through their students, graduates, researchers, faculty and community service programs) will not only help prevent illness but will also help slow down the rapidly escalating costs of medical care. Providing basic institutional and student support is a means whereby the Federal government can share the costs with state and private institutions for the training of public health personnel to manage and operate governmental health programs. Public health is a public responsibility. Schools of Public Health train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH thanks the Members of the Senate Appropriations Subcommittee on Labor/HHS/Education for the opportunity to present its views on the FY1982 appropriations bill. We urge favorable consideration of our requests outlined in this statement.

TABLE I
Budget History
Public Health Training Appropriations
(Constant Dollars)[1]
1964 - 1980

ar	No. Schools	GNP Deflator	Total[2]	Project[2]	Formula[2] (Institutional Support)	Traineeships[2]
1964	14	63.3	$12,788,300	$3,159,550	$3,001,570	$6,627,170
1965	14	65.1	14,592,900	3,840,240	3,840,240	6,912,440
1966	15	68.4	21,198,800	5,847,950	5,116,950	10,233,910
1967	15	72.5	23,103,400	6,896,550	5,172,410	11,034,480
1968	15	76.9	21,456,400	5,851,750	5,201,560	10,403,120
1969	16	81.9	21,332,100	6,003,660	5,560,430	9,768,000
1970	16	88.3	20,465,400	5,568,516	5,836,910	9,060,020
1971	17	94.5	19,016,900	4,779,890	5,348,140	8,888,880
1972	17	100.0	18,471,000	4,517,000	5,554,000	8,400,000
1973	18	107.5	20,093,000	5,581,390	5,581,390	8,930,230
1974	18	118.9	17,258,200	4,793,940	4,793,940	7,670,310
1975	19	127.3	16,119,400	4,320,500	4,634,720	7,164,180
/6	19	137.7	14,901,900	3,994,190	4,284,670	6,623,090
1977	19	146.2[3]	14,035,500	3,761,970	4,035,560	6,238,030
1978	21	150.3[4]	11,909,500	3,326,680	3,925,480	4,657,350
1979	21	162.7	10,947,113	3,071,819	3,624,747	4,300,547
1980	21	177.3	10,431,350	2,819,284	3,665,069	3,946,997

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[1] Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

[2] Rounded

[3] Second Quarter 1977

[4] Estimated

TABLE II
Appropriations History
Public Health Institutional Support
Current and Constant Dollars
1964 - 1980

Fiscal Year	No. Schools	Appropriation	(State/local gov't) GNP Deflator[1]	Appropriation (in constant dollars)[2]
1964	14	$1,900,000	63.3	$3,001,570
1965	14	2,500,000	65.1	3,840,240
1966	15	3,500,000	68.4	5,116,950
1967	15	3,750,000	72.5	5,172,410
1968	15	4,000,000	76.9	5,201,560
1969	16	4,554,000	81.9	5,560,430
1970	16	5,154,000	88.3	5,836,910
1971	17	5,054,000	94.5	5,348,140
1972	17	5,554,000	100.0	5,554,000
1973	18	6,000,000	107.5	5,581,390
1974	18	5,700,000	118.9	4,793,940
1975	19	5,900,000	127.3	4,634,720
1976	19	5,900,000	137.7	4,284,670
1977	19	5,900,000	146.2[3]	4,035,560
1978[5]	21	5,900,000	150.3[4]	3,925,480
1979	21	5,900,000	162.7	3,624,747
1980	21	6,500,000	177.3	3,665,069

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[1] Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

[2] Rounded

[3] Second quarter 1977

[4] Estimated

[5] First year for Capitation grant allocation

TABLE III

Budget History

Public Health Traineeship Appropriations

(In Current and Constant Dollars[1])

1964 - 1980

Year	No. Schools	(Current $) Traineeships	GNP Deflator	(Constant $) Traineeships[2]
1964	14	$4,195,000	63.3	$6,627,170
1965	14	4,500,000	65.1	6,912,440
1966	15	7,000,000	68.4	10,233,910
1967	15	8,000,000	72.5	11,034,480
1968	15	8,000,000	76.9	10,403,120
1969	16	8,000,000	81.9	9,768,000
1970	16	8,000,000	88.3	9,060,020
1971	17	8,400,000	94.5	8,888,880
1972	17	8,400,000	100.0	8,400,000
1973	18	9,600,000	107.5	8,930,230
1974	18	9,120,000	118.5	7,670,310
1975	19	9,120,000	127.3	7,164,180
1976	19	9,120,000	137.7	6,623,090
1977	19	9,120,000	146.2[3]	6,238,030
1978	21	7,000,000	150.3[4]	4,657,350
1979	21	7,000,000	162.7	4,300,547
1980	21	7,000,000	177.3	3,946,997

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[1] Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

[2] Rounded

[3] Second quarter 1977

[4] Estimated

TABLE IV
Budget History
Special Projects in Public Health
(Current and Constant Dollars[1])
1964 - 1980

Year	(Current $) Project	GNP Deflator	(Constant $)[2] Project
1964	$2,000,000	63.3	$3,159,550
1965	2,500,000	65.1	3,840,240
1966	4,000,000	68.4	5,847,950
1967	5,000,000	72.5	6,896,550
1968	4,500,000	76.9	5,851,750
1969	4,917,000	81.9	6,003,660
1970	4,917,000	88.3	5,568,516
1971	4,517,000	94.5	4,779,890
1972	4,517,000	100.0	4,517,000
1973	6,000,000	107.5	5,581,390
1974	5,700,000	118.9	4,793,940
1975	5,500,000	127.3	4,320,500
1976	5,500,000	137.7	3,994,190
1977	5,500,000	146.2[3]	3,761,970
1978[5]	5,000,000	150.3[4]	3,326,680
1979[5]	5,000,000	162.7	3,071,819
1980[5]	5,000,000	177.3	3,065,069

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[1] Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

[2] Rounded

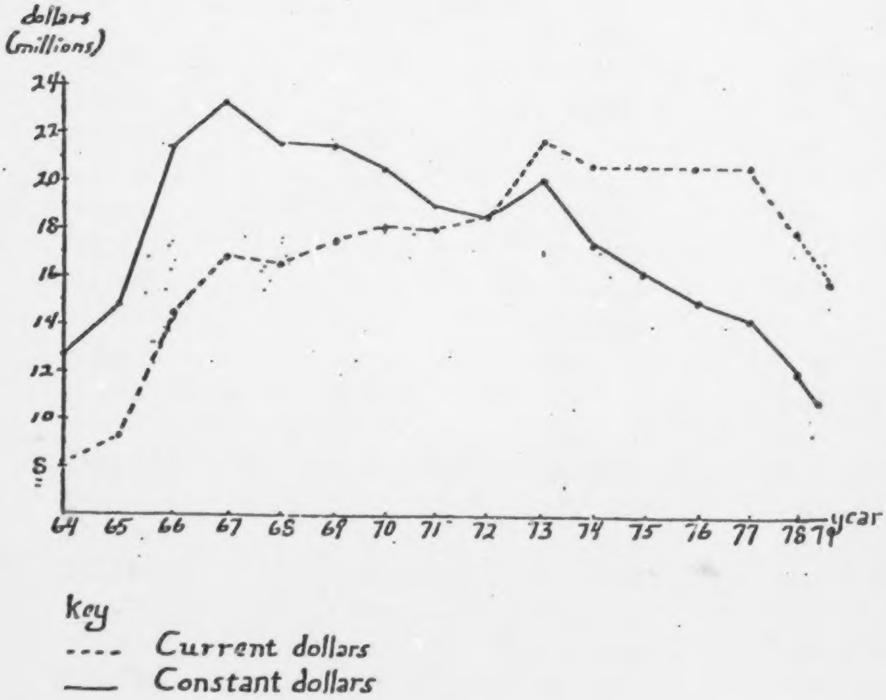
[3] Second quarter 1977

[4] Estimated

[5] Number of Schools of Public Health: 21

Attachment A

Appropriations History
Current and Constant Dollars
1964-1979



Some Highlights of the Preliminary Data on 1978 and 1979 Graduates

1979	1978	
		Employment
78.4%	82.3%	of the graduates are employed
12.0	12.8	of the graduates have continued their education
9.0	4.2	of the graduates are unemployed
		Type of Employing Organization
50.4%	52.0%	of employed graduates work for tax supported organizations such as Federal, State, Regional or Local Government
26.0	22.2	of employed graduates work for Voluntary Health Agencies
12.5	12.2	of employed graduates work for Proprietary Organizations
		Types of Services Which Graduates are Providing
32.1%	38.1%	of graduates are providing Administrative, Planning or Evaluation Services
15.4	14.0	of graduates are providing Education and Training to others in Public Health
9.1	9.1	of graduates are providing Consultation Services
5.1	3.3	of graduates are providing Public Health Community Organizational Services
38.3	35.5	of graduates are providing Technical Services such as Clinical, Laboratory, Social and Environmental Services
		Earning Levels of Employed Graduates
5.8%	48.0%	or almost one-half of employed graduates earn less than $19,000 per year
16.6	20.0	of employed graduates earn between $19,000 to $22,000
6.2	11.0	of employed graduates earn between $22,000 to $25,000
20.4	21.0	of employed graduates earn more than $25,000
		Earning Level of Graduates Prior to Public Health Training
77.4%	83.0%	of graduates earned less than $19,000
6.0	6.8	of graduates prior to entering SPH earned between $19,000 and $22,000
4.4	3.0	of graduates prior to entering SPH earned between $22,000 and $25,000
12.2	7.2	of graduates prior to entering SPH earned more than $25,000
		Financial Assistance During Training
77.2%	76.0%	of the graduates had some financial assistance during their education
29.5	33.0	of the graduates had more than 2/3 of their education paid by traineeship, grants or employers
		Job Availability for Graduates with Public Health Degrees and Experience
53.9%	62.7%	of graduates with work experience found jobs readily available

Those graduates without prior experience found it more difficult to obtain satisfactory jobs.

1990 REQUIREMENTS FOR PUBLIC HEALTH AND PREVENTIVE MEDICINE

Manpower estimated by GMENAC

On September 23, 1980, the HHS Graduate Medical Education National Advisory Committee (GMENAC) met in Washington and adopted final recommendations (shown below) regarding the needed number of public health physicians for each specialty for 1990.

Present Supply	Aerospace Medicine	Occupational Medicine	Public Health and General Preventive Medicine	Total
Board-certified(1)	783	794	2,317	3,894
Self-identified(2)				
Administration	165	541	1,555	2,291
Research	27	28	201	256
Teaching	7	9	115	131
Patient Care	368	(1,695)*	(1,048)*	368
Other	17	78	147	242
	584	656	2,048	3,288
1990 Requirements for Board-Qualified Full Time Equivelents (3)				
Program Activities	250	1,400	2,100	3,750
Research	150	200	400	750
Touching	60	300	450	810
Clinical Services	500	400**	400**	1,300
Other	0	0	200	200
	960	2,300	3,550	6,510

The estimate of total requirements as calculated above is 6,800-7,500.

Shortage				
Number	376	1,644	1,502	3,522
Percent	64	251	73	107

*These are felt to be physicians providing regular clinical services though in a preventive medicine setting. The 2700 physicians have not been included in the final figures because in the GMENAC methodology these physicians have been includ-d in the enumeration of generalist physicians.

**These are in addition to other physician specialists working in a preventive medicine setting but who are providing regular clinical services.

STATEMENT OF DANIEL W. SIGELMAN, PUBLIC CITIZEN

Senator Inouye. I would now invite the following: Representing the Gray Panthers, Ms. Frances Klafter; representing the National Health Law Program, Ms. Judith Waxman; representing the National Citizens' Coalition for Nursing Home Reform, Ms. Elma Griesel; representing Public Citizen, Mr. Daniel Sigelman; representing the Consumer Coalition for Health, Ms. Penelope Jacks; and representing the New Jersey Department of the Public Advocate, Mr. Edward Tetelman.

I would like to call a 5-minute recess at this time.

[A brief recess was taken.]

Senator Inouye. Sorry to keep you waiting. Our first witness will be Mr. Daniel Sigelman, representing a public citizen; then Ms. Judith G. Waxman, for the National Health Law Program; then Ms. Frances Klafter on behalf of the Gray Panthers National Health Task Force; then Ms. Elma L. Griesel, Executive Director of the National Citizens Coalition for Nursing Reform.

Mr. Sigelman. I am also speaking for the Consumer Coalition for Health. The public citizen research group is a group that has researched for and advocated the rights of consumers. The administration's proposal to cap increases in medicaid contributions at an annual rate of 5 percent thinly masks a threat to the health and unfortunately the lives of many low-income Americans.

President Reagan has vowed that none of his budget cuts, including those slated for medicaid, will hurt the truly needy. But by definition, medicaid only serves the neediest among our citizens. If anything, it reaches too few, not too many of the poor and disadvantaged.

States which exercise considerable discretion over medicaid eligibility requirements have left an appallingly high 47 percent of Americans below the poverty line, unprotected by medicaid coverage. Anywhere from 60 to 76 percent of persons at or below the poverty line do not have such coverage in one-half of all States.

Senator Inouye. Do you have a list of those States?

Mr. Sigelman. I could furnish them. The list actually appears in the American Medical News in the late January issue. The list comes from data from the Health Care Financing Administration for calendar year 1979.

Senator Inouye. If you will provide that, I will put that in the record.

[The information follows:]

[From the American Medical News, Jan. 30, 1981]

MEDICAID COVERAGE

Medicaid jurisdiction	Percentage of persons living at/or below the poverty level receiving medicaid services	Average expenditures per medicaid recipient
Massachusetts	115	$796
Hawaii	94	784
California	93	774

MEDICAID COVERAGE—Continued

Medicaid jurisdiction	Percentage of persons living at/or below the poverty level receiving medicaid services	Average expenditures per medicaid recipient
Rhode Island	92	1,040
New York	79	1,689
District of Columbia	72	1,062
Maine	71	728
Pennsylvania	69	854
Puerto Rico	68	58
Oregon	67	719
Maryland	66	871
New Jersey	64	995
Michigan	58	1,155
Wisconsin	58	1,396
Alaska	57	1,554
Illinois	55	976
Connecticut	53	1,348
U.S. AVERAGE	53	955
Delaware	52	862
Washington	51	1,062
Minnesoto	47	1,558
Kentucky	46	612
Vermont	44	1,075
Kansas	43	1,096
Louisiana	42	881
Oklahoma	42	976
Colorado	40	1,082
Ohio	40	923
Alabama	39	731
New Hampshire	39	1,367
Iowa	37	1,232
South Carolina	37	773
Utah	37	1,183
Virginia	35	995
Arkansas	34	901
Missouri	34	706
Tennessee	33	994
Montana	32	1,265
Wyoming	32	1,047
Georgia	31	954
Idaho	30	1,089
New Mexico	30	682
North Carolina	30	867
Indiana	29	1,390
Mississippi	26	226
Nevada	26	1,471
West Virginia	26	890
Florida	24	784
Nebraska	24	1,360
North Dakota	24	1,449
South Dakota	24	1,396
Texas	24	1,275

N.—This table shows the percentage of people living at or below the poverty level, ranked in descending order, who received medicaid in 1979, and the average expenditures per medicaid recipient by jurisdiction that year. (Arizona has no medicaid program, and the Virgin Islands and Guam were deleted from the table because of problems with the data.) Source of the data is the Federal Health Care Financing Administration.

Mr. SIGELMAN. Those who are fortunate to qualify for medicaid, not surprisingly, are by any reasonal and humane account among our Nation's neediest and most vulnerable people.

Approximately one-half of all medicaid enrollees are children who qualify for aid to children or AFDC benefits. The medicaid cap in conjunction with imposed administration restriction on AFDC State eligibility would probably deprive millions of children, especially in those of low-income two-parent homes, of much needed health care services.

That the administration promises to leave medicare benefits temporarily intact is hardly any consolation to the one in every five older Americans now absolutely dependent on medicaid.

In addition to the 4.2 million elderly disabled and blind persons now receiving medicaid benefits, approximately 3 million of the Nation's elderly rely on medicaid to pick up the stiff deductibles, coinsurance, and the physician services premium payments which medicare normally requires its beneficiaries to pay. Medicaid is also the major payer for nursing home services.

In fiscal 1979, medicaid furnished 49.5 percent of all skilled and intermediate carriers in home reimbursement. Fully 45 percent of all medicaid dollars currently go to nursing home facilities. If recent history is any indication, many States will simply limit benefits and/or tighten eligibility requirements in response to a diminished Federal medicaid role.

Even the Office of Management and Budget black book, outlining proposed administration budget cuts, conceded that some States are likely to respond to the cap by withdrawing needed services from it. The Federal Government should not retreat from its commitment to the poor and disadvantaged by forcing States arbitrarily to make a fine and I think unjustified distinction between the "generally and truly needy," and the merely "truly needy." Compassion, humanity, and as some of my colleagues will further explain, fiscal foresight demands that Congress rejects the administration's proposal to impose a restrictive ceiling on Federal contributions to rising medicaid costs.

I might add that we are not just talking today about dollars and cents and the techniques and technicalities of budget control, but we are talking about the health and unfortunately the lives in many cases of some of our society's most vulnerable people and I urge total wholesale rejection of any cap on the rise in medicaid expenditures.

Senator INOUYE. I gather from your testimony that at the present time the treatment provided to citizens throughout the United States is not quite equal because of States having the flexibility of determining eligibility, isn't that correct?

Mr. SIGELMAN. That is correct. And in effect, as the testimony of the National Health Law Program points up, we would be freezing into place many of the irrational disparities that now exist among the several States with respect to the benefit levels and eligibility requirements by imposing a stringent cap on Federal medicaid contributions.

Senator INOUYE. You are suggesting this cap may just compound the problem?

Mr. SIGELMAN. Yes; in my written testimony I indicate how I think in the long run it will not save money. I think that ultimately, what it will probably force States which cannot absorb the increased costs of medicaid to do would be to cut back eligibility and benefits and as one expert, Bruce Spitz, who is writing for the National Governor's Association, indicated, all this would accomplish would be a short-term one-side only cut in units of service, numbers of units of service. But in the aggregate, it would do little to stem the incremental rise in costs of those units and over a very short period of time, we would be back with the same level of inflation we have now, with a great deal of suffering having ensued.

Senator INOUYE. Where can the poor people go if they can't get assistance on the medicaid program?

Mr. SIGELMAN. There are very few places they can go unless they have access to a public hospital, for example the Hill-Burton, if they could find one, they have very few places to go. Many public hospitals are closing under the fiscal strains of urban and State budget and with respect to the Hill-Burton, most hospitals are not observing their requirements and only operate under a 20-year period, in which they have to offer free care.

So it is very possible that many of these people simply will go without care. I think in all likelihood, it is quite probable.

Senator INOUYE. Thank you very much. The next witness is Ms. Judith G. Waxman, representing the National Health Law Program.

STATEMENT OF JUDITH G. WAXMAN, NATIONAL HEALTH LAW PROGRAM, INC.

Ms. WAXMAN. I would like to say from the outset that the New Jersey Department of the Public Advocate that could not appear here today has asked to lend their support to our statement.

Senator INOUYE. Thank you. It will be noted.

Ms. WAXMAN. Thank you. The National Health Law Program is the national support center which provides professional advice and assistance to poor people and their advocates throughout the country on matters concerning equitable access to quality health care.

The National Health Law Program is opposed to the administration's proposal to reduce funding for medicaid by an arbitrary cap on expenditures.

Medicaid recipients, the population group most truly in need is being asked to bear the full brunt of efforts to cut health expenditures. The proposal will cause drastic cutbacks in eligibility and thereby access to health care for the very poor.

Additionally, this proposal fails to address the primary causes of escalation in public health care expenditures. You have already heard who medicaid presently serves. It is inadequate now and are the poor responsible for increases in medicaid costs? It is commonly mentioned that medicaid costs have risen uncontrollably but what is causing State medicaid expenditures to rise? Increases in eligibility, or services?

Is it increase in utilization or increase in rates and fees for health services? Increases in rates and fees for hospitals, nursing homes, doctors, pharmacists, and other providers account for 80 percent of the increased medicaid costs. Eligibles have not increased. In fact, data show that eligibility has dropped by about 1.8 million since 1975.

The few real increases in services in recent years have been for less costly alternatives to nursing home care, for example, and what will be the likely effect of the proposed cap?

The major predicter of what States will do in response to that kind of cut can be judged by what States have done in the past in the face of their own budgetary crises. Over the past year, in the absence of a proposed reduction in the Federal funding, 25 States that face budgetary problems have asked for extensive cuts in medicaid eligibility and services. This is going to mean that programs like the medically needy program, which is generally for chronically ill or older people will be cut from the roles. Additionally, children in two-parent homes and other optional eligibles will also be cut.

In addition to cutting eligibles, States across the board have proposed cuts in services. Not all of them have gone through.

Surely they will, if the cut in Federal funding is passed.

Eight States have imposed limits on recipients' access to hospital care. They have proposed limits on physicians' visits and severe restrictions were proposed on many of the so-called optional services such as prescription drugs, physical therapy, dental care, mental health, wheelchairs, and medical supplies, orthopedic and vision services. These are the so-called optional services.

Furthermore, this proposal will only result in one-time savings and it will undermine efforts to rationally control costs which would have a longer term effect on health care expenditures.

Right now, hospitals and nursing homes account for about 70 percent of the medicaid budget. A number of States in recent years have attempted to adopt a variety of rational medicaid cost containment measures. These measures have ranged from improved administration and third-party collections to alternatives to institutional savings.

Some States have set up mandatory perspective rates and in these days they have held hospital rate increases at 4 percentage points lower than rates in States without rate setting.

Utilization review mechanisms in some locales have saved medicaid dollars by containing medically unnecessary services. These cost containment strategies need to be strengthened.

However, the new administration's approach, which will allow all kinds of flexibility to the State, will imperil even these modest gains. So at the same time that medicaid expenditures will be reduced, controls will be lifted from their biggest cost component.

We believe that medicaid and health care cost containment directed at the major causes of cost increase and waste should not only be pursued but should be mandated.

We also believe that if budgetary cuts are to be required, they should be imposed in an equitable manner. One in which the truly needy would be hurt the least.

The administration's proposals fail to address either of these goals. They place the full burden of health care financing reform on those least able to shoulder the rope. Thank you.

Senator INOUYE. Thank you very much, Ms. Waxman. Our next witness is Ms. Frances Klafter, representing the Gray Panthers.

STATEMENT OF FRANCES KLAFTER, GRAY PANTHERS

Ms. KLAFTER. I am speaking for the Gray Panthers, who though composed of young and old members much concerned about the quality of life for people of old ages, have been particularly concerned about health care for the elderly because of the extreme vulnerability of the elderly and their more complicated type of problems.

We Gray Panthers have been particularly interested in and involved in questions of our whole health care system, and have felt very much that something needs to be done about it. That it needs much improvement. But we certainly don't think putting a cap on Federal funding and medicaid is that something that should be done.

When we talk about putting a cap on Federal funding of medicaid, we are talking about capping the number of dollars for a program which is designed to meet the needs of the millions of poverty stricken, the ill, the aged, and no one has found a way to put a cap on them.

The press has convinced many of us that we are faced with the possibility of a butcher-like approach at cutting health care expenditures, considering dollars and forgetting about the people behind these dollars, ignoring the fact that depriving many people of health care not covered by medicaid would sound their death knell.

We can assume that if a cap is placed on Federal funding for medicaid, the States already financially hard-pressed and faced with the threat of other massive cuts in Federal funding would find it necessary to drop one or more of the options permitted to them under the program.

One such option at present is the inclusion of the medically needy, those people above the public assistance level whose medical bills have pushed their incomes well below the poverty level. Who are these people? The medically needy?

Who would undoubtedly be the first victims of a cap on Federal funding and medicaid? Actually, many of them are Gray Panther members and I—I am quite well acquainted with many others, particularly in Washington, D.C., because we have joined with other citizens groups for some years in consistently opposing efforts to remove them from the medicaid rolls in the District of Columbia.

You might say we have also been successful in convincing the financially hard-pressed District not to remove them from the rolls.

These people include minor children and families of the working corps, people who have been financially wiped out with serious illnesses requiring expensive treatment and many elderly whose incomes will not stretch to cover their unexpected costly health care expenditures.

These elderly people count on medicaid to supplement the small portion of their health care costs covered by medicare, now about 38 percent.

They need help in paying large expenses, for example, such as nursing home care or home care and relatively small expenses such as the cost of prescription drugs, which they cannot afford and perhaps without which they could not survive. Medicaid is part of the social safety net which the President has vowed will be left intact. What is to become of these people if they are cut from the medicaid rolls? Few States and localities are prepared to serve them under their medical charities program.

Consider, for example, the elderly and disabled requiring home health care, now financed in many States by the medicaid program and only marginally financed by the medicare program. This country has to make up its mind whether it is going to take care of the elderly after we pass a stage of happy retirement, spent in helpful recreational activities and useful community services. It is one of these people still in that happy State of retirement that I have long been concerned about, this being the picture of the elderly in our country and those that are perfectly willing, as a nation, to talk about. I'm talking about some other elderly today. Those that Dr. Butler calls the old old. Those that, as a nation, we must decide if we are going to take care of.

I don't know whether you know, but many social workers and others responsible for caring for helpless elderly frequently do when they are faced with the desperate situation of an elderly ill and helpless person for whom no home care or community services are available. They take them to hospitals and they leave them there. They don't do this because they are cruel. But because the alternative would be to leave them completely uncared for in their homes, and the assumption is that at least it will take a while before the hospital can think—figure out something to do with them and get them out of the hospital. So, actually, the viability of community services financed for medicaid can prevent such desperate measures.

The administration claims that proposed budget cuts will be equitable. What I would like to point out is that Federal programs for the poor were designed to help correct inequities. In the case of medicaid, unequal access to health care. Until the inequity this program was designed to correct has been removed, cuts in it can in no way be considered equitable.

President Reagan, in presenting his proposals for his economic program to the Congress, asks citizens to speak up if they have an alternative which offers a greater chance of balancing the budget, reducing and eliminating inflation, stimulating the creation of jobs, and reducing the tax burden.

Even if I were an economist, which I am not, I would not undertake to address these questions in my brief time before this subcommittee.

I would like to say for the record, however, what everyone already knows and that is that an increase in defense expenditures will not do any of these things. Though this is outside the purview of this hearing, what we are really considering when we consider any part of the national budget is national priorities. What expenditures will add the most to the health, security, and well-being of the people of this country?

On the specific question of alternatives to the proposed cuts in health expenditures, we hope that this subcommittee will take a thorough look at all federally funded health programs in order to determine which of them are serving the population well and which are inefficient and wasteful. And that it will not opt for indiscriminate and hasty cuts that would leave entire segments of the population without health care, particularly preventive health care which, in the long run, would save the Nation many millions of health care dollars.

These are all interrelated in terms of meeting people's needs and how the money can best be spent to do so. It is awful to think of them as which Federal agency funds which program. For example, simultaneously with a proposal to fund the medicaid program the National Health Service Corps is being virtually wiped out despite the fact that it is providing much needed health care in many impoverished areas. With the curtailment of services in community health centers staffed wholly or in part by national health services personnel, many patients remaining on the medicaid rolls will be forced to turn to expensive private doctors, often practicing in medicaid mills.

Other patients being cut will be forced to go without medical care until their illnesses reach a much more expensive critical stage for which the public must bear the costs of treatment or let them die. The ultimate alternative to which this country will surely some day turn because it is the most efficient and economical way to deliver health care to the people, is adoption of a community-based federally funded health policy, which was proposed.

But, that is a long way down the pike and in light of the current approach to funding health programs, it seems like an unrealistic dream. But our Canadian neighbors and our British cousins have found that they can provide complete health care to their people at a much lower per capita cost than we are now spending for health care.

Thank you very much.

Senator INOUYE. I thank you very much, Ma'am. Our final witness is Elma L. Griesel, executive director of the National Citizens' Coalition for Nursing Home Reform.

STATEMENT OF ELMA L. GRIESEL, EXECUTIVE DIRECTOR, NATIONAL CITIZENS' FOR NURSING HOME REFORM

Ms. GRIESEL. Good afternoon, Senator. We certainly appreciate your staying and listening to us personally and I'm going to take it as an indicator that you personally care about what happens to the beneficiaries of the medicaid program and I congratulate you for that.

Senator INOUYE. I may not be a majority.

Ms. GRIESEL. We are seriously concerned that if there are cuts in the medicaid program that this is going to drastically affect residents who live in nursing homes and we are particularly concerned about this because, even though the expenditures for nursing home care in this country are primary, they still do not provide for any kind of general adequate care for nursing home residents.

In fact, we have in facilities around the country poor to minimal care, as established by the Federal standard for nursing homes, so it is a grave concern to us that we might have further cutbacks in an already inadequate program. I know you have been given some statistics, but I would just add a couple of more statistics that I think are really important because most elderly persons in America's nursing homes are supported by taxpayers' dollars, primarily because they have no other source of support. Over 70 percent of the elderly institutionalized medicaid recipients are widowed or single females above the age of 70, almost one-half, 46 percent, of all institutionalized elderly are childless. There is nobody to provide for their support. We have, as far as statistics on health insurance, we have an indicator that only 1.5 percent of private nursing home expenditures are made for nursing home care and that compares to 74.5 percent of private hospital expenditures being paid by private insurance.

Most Americans in need of nursing home services cannot afford to pay the costs because the costs are so high. The average cost of nursing home care is over $800 per month. And in any of the facilities that provide any kind of quality of care, these services or the cost is usually $1,000 to almost $2000 and sometimes over $2,000 a month. So, you can tell that the services that are available in nursing homes in the better facilities are only available to those people who can afford it and to the higher income families.

Another statistic that I think is very viable to this program is that most people that are now on medicaid in nursing homes did not start out to be medicaid residents. Of the people who are now on medicaid, 47 percent are in nursing homes, and probably over 47 percent this year, started out as private patients and literally paid thousands and thousands of dollars into the system before they ran out of funds and were forced to go on to a medicaid program. So, people are not—they don't set out to get on the medicaid program. In addition, what we are facing around the country is that medicaid beds are just not available. The way the system is set up now, the nursing home providers look for private patients in order to supplement the payments that they get in the program. And it is really unfair to all Americans because private patients really subsidize the care that is given in nursing homes and unfortunately, even though they subsidize the care, they are still not getting quality services because they are in the same kind of facilities.

Generally there are the same problems, so they are still subjected to the same abuses and neglect that nursing home residents often are encountered with. Our information is based on current studies by over 25 State legislatures. In different reports around the country, State legislators are looking at their medicaid program, certainly finding that it is too costly, but they are also finding that their system is not providing adequate care. In fact, their systems are providing minimal care. Even at this, they are already starting in the last couple of years to cut back on the services.

We do not know, with the provision of moneys that we have, the substantial amount of moneys that are going into nursing homes, we do not have rehabilitative services for residents, we do not have social services, mental health services, we do not have enough medical care. Food is often inadequate. We know from our studies around the country and direct experience of our member groups and families and friends of nursing home residents, fresh fruits and vegetables are rarely served in nursing homes. So we really have major problems in the current system. If we cut back, those kinds of services will be further cut back.

There is an additional major problem involved and that is that the workers in health care facilities in nursing homes are really suffering from major abuses because of the lack of funds in the system or because of the lack of the nursing home industry's emphasis on providing adequate wages, supervision, and training and supplies with which the nurses and the nurses' aides and other workers can do their job.

So, when we have a system that abuses the people who work in the facilities, who do arduous labor that is emotionally draining, just commonsense tells us that this is going to make services to the elderly in institutions even more inadequate because the frustrations and the problems of the workers are going to be reflected in patient care.

We have found in one State, the State of Washington, that a study was done and it was determined that the workers in nursing homes, their wages were so inadequate that they were eligible, many of the workers in Spokane, Wash., are eligible and receive other public benefits because they cannot support their families on the wages that they make in nursing homes.

So we not only have problems in the medicaid system, we have actually other public programs that subsidize the nursing home industry even further. We also are faced with an inadequate inspection and enforcement system and there is no way to get around that. There are not enough people employed in State regulatory agencies to do an adequate job of monitoring to assure any kind of level of quality care in nursing homes.

We understand that the newest cutbacks in the medicaid program, will relate to the cutback on inspections and surveys. If that happens, and we do cut back on regulations which are already minimal, we will, I am quite sure, in 2 or 3 years, be back in the early 1960's as it relates to conditions in nursing homes. We will have tremendous scandals in this country and somehow we are going to have to be able to deal with that when that happens.

So, we have an inadequate regulatory system; at the same time the new administration is proposing to cut back in minimal regulations. There are ways that cuts in the medicaid programs can be cut. There is no question about it. It has been mentioned or referred to, better placement programs, so that people who are placed by the medicaid program receive the appropriate level care at the lowest cost.

Certainly, we need more efficient regulatory agencies. This is going to be more expensive but, in the long run, if we have better care in nursing homes, it will mean that less nursing services, medical services would be needed and also that less hospital services will be needed because so often now we find residents of nursing homes transferred out of nursing homes into hospitals because of the poor treatment that they receive there.

We can cut back on expenses that are now paid for under the medicaid program to nursing home providers such as high costs for travel, education, and personnel expenditures. We can also improve our financial auditing programs because we have that by State, the auditing programs are insufficient and there are not—there are very few audits going on, very few field audits of nursing homes to really determine what the expenditures are.

So, there are ways that we can cut back on costs, we obviously support any kind of changes that can be made to cut back those costs but, at the same time, we think that it would be terribly irresponsible, if not criminal, to cut back on money that is in the long run going to mean only minimal subsistence for nursing home residents.

We thank you again for the opportunity to give our statement to the subcommittee.

Senator INOUYE. Thank you very much, Ms. Griesel. I am certain that all of you have read accounts of alleged abuse and fraudulent practices in the administration of the medicaid program.

Are you aware of medicaid recipients, of medicaid patients being involved in the fraud or abuse?

Ms. KLAFTER. I think probably I have something to say about that. I think we are much more aware of the fraud and abuse on the part of the providers. Undoubtedly there is some on the recipients' part, but as I pointed out to somebody who was complaining about food stamps, I said you bear in mind that the relevant fact that the food stamp program is saving people from starving and those minor things are not consequential.

The minor abuses on the part of some individuals in the medicaid program, that in the overall picture, that it is irrelevant.

Mr. WAXMAN. Excuse me, Senator, not long ago we had some recipients from Alabama come to testify on the House side on some other medicaid expenditures proposal and the same question came up at that time. The statistics that they had from their own State was that 98 percent of the fraud was by the providers and 2 percent by recipients.

Now, I can't say for sure that that is the exact statistics across the country, but, in fact, my guess is that it leans much more in that direction.

Senator INOUYE. The President's program will be penalizing the recipients when he should be penalizing providers.

Mr. WAXMAN. That's right. I mean, no doubt there is fraud that can be found in the system. As I say, we think it should be mandated to find that fraud and end it. But when I look at the proposal that will no doubt result in decreased eligibility and decreased services, it is the recipients that will be hurt and the fraud and the rising costs will not be attacked by that proposal.

Senator INOUYE. Well, all of you have been very patient. It is 6 o'clock now, we should have left here by 4 p.m. But I am happy you waited. Your testimony and that of the others will be treated very carefully. We will study them. I can assure you that I will read all of the prepared text and we will do what we can. Obviously, the drive to cut down the cost of running this Government cannot be stopped. Something must be done. If you do have suggestions on how we can bring about economies, the subcommittee will appreciate it.

Mr. WAXMAN. Thank you, we will.

Senator INOUYE. We will try to get as much as we can, but sometimes things do happen.

Mr. WAXMAN. I think we all agree that there can be cuts in the budget, but we hope that they will be rational rather than just arbitrary cuts that will hurt people and not really help the system.

Senator INOUYE. So, ladies and gentlemen, thank you very much.

[The statements follow:]

Statement of Judith G. Waxman

A MEDICAID CAP IS ILL-ADVISED, AND UNDULY HARMFUL TO THOSE MOST IN NEED

A civilized society allocates medical care on the basis of need. It is apparent to Medicaid recipients that The administration's proposals to Congress are a wholesale retreat from society's tentative steps towards a just and sensible distribution of health resources. It is not the cut in dollars that creates this perception---it is the unequal distribution of the burden of such cuts. Medicaid recipients, the population group most truly in need of health care services, are to bear alone the full brunt of efforts to curtail health care expenditures. The Administration's proposal to cap Medicaid expenses, will certainly cause drastic cutbacks in eligibility and thus access to health care for the very poor. But this proposal fails totally to address the primary causes of the escalation in public health care expenditures.

The National Health Law Program is a legal services support center which provides professional advice and assistance to poor people and their advocates throughout the country. NHeLP supports the efforts of the poor and minorities to gain equitable access to quality health services to meet their medical needs. We join the many individuals and organizations, including the National Governor's Association, who believe the proposed Medicaid cap is ill-advised, misdirected, counter-productive and unduly harmful.

THE PATHS NOT TAKEN IN REDUCING HEALTH CARE COSTS

Medicaid recipients might have less reason to complain if all segments of society were required to equally shoulder the hardships implicit in a new beginning. But that is not the case. Do we see a proposal to cap Medicare? No. Do we see a proposal to cap Veteran's health care? No. And yet the coverage of those programs is not limited to the "truly needy," as Medicaid is limited. Do we see a proposal to cap federal employees' and officials' insurance costs? No. Do we see a proposal to cap hospital costs, which have been escalating 18% a year? On the contrary; there is talk of decontrolling costs. Do we see a proposal such as was sponsored by Rep. Stockman last year to reduce tax deductions for excessive medical costs by, for example, moving the threshold from 3 to 4%? No. Do we see a proposal such as was sponsored by Rep. Stockman and Sen. Schweiker to limit business tax deductions and the exemption from personal income tax for the costs of medical insurance? Or even simply a modest step of giving credit and exemption for only a 5% growth in the costs of health insurance? No on both counts. Rep. Stockman and Sen. Schweiker alleged just last year that these villanous provisions were responsible for the uncontrolled growth in medical costs; yet this year when they have the power to take realistic steps to control that growth and save federal dollars, they have chosen to place the burden solely on Medicaid recipients.

WHO DOES MEDICAID SERVE?

Let us examine if there is a particular reason to visit this reduction exclusively on Medicaid recipients. First, let us look at who Medicaid covers. Medicaid is the primary financing vehicle for health care for the nation's poor---the elderly, the disabled, and children. Sixteen percent of the recipients and 38 percent of the dollars are devoted to the needs of the elderly poor; while 50 percent of the eligibles and 19 percent of the dollars go for health care to needy children. Twenty-one percent of the nation's elderly receive Medicaid. In fact, approximately 3 million elderly and disabled recipients of Medicare---a program whose beneficiaries the Administration considered "untouchable"---rely on Medicaid to pay for their deductibles, coinsurance, and many services that Medicare does not cover. Medicaid does not even reach all the poor in this country---44% of all poor children and 42% of the elderly poor are currently denied Medicaid.

The health indicators for the poor show they suffer twice the illness, disability, and restrictions on activity rates of the non-poor. The Medicaid poor are disabled, and aged in much higher percentages than the general population. Medicaid has worked; it has dramatically increased the ability of the poor to gain access to physician, hospitalization and other health care services at rates somewhat equivalent to that of the generaly population. Despite this increase, a study has shown that Medicaid recipients---because they are in such poor health---actually use doctors and other health services *30% less* than their need requires. And, despite the greater sickness suffered by the poor, the costs of Medicaid for an AFDC family of four are much less than the costs of a comparable insurance policy for a non-poor family of four.

ARE THE POOR RESPONSIBLE FOR INCREASES IN MEDICAID COSTS?

Next, let us look at the money that is spent on Medicaid. It is commonly alleged that Medicaid costs have risen uncontrollably, and that Medicaid is unduly expensive. It is vital to consider some fundamental facts about Medicaid expenditures. Medicaid recipients are quite conscious of and supportive of the need for cost containment; they know from bitter experiences that cost increases generally prompt curtailments in eligibility and services.

The annual Medicaid spending growth rate over the past five years has in fact been much lower than the annual CPI growth in medical care, and much lower than the growth rate of other areas of federal health spending. What, then, is causing state Medicaid expenditures to rise? Is it increases in eligibility or services? Increases in utilization? Or increases in rates and fees for health services? *Increases in rates and fees for hospitals, nursing homes, doctors, pharmacists, and other providers account for 80 percent of the increased Medicaid costs*. Increases in what may be called "fiscal relief" services* account for between 10 and 15 percent. Eligibles have not increased; in fact, data show that *eligibles have dropped by about 1.8 million since 1975* and have been steady for the past 3 years. Approximately 70% of Medicaid expenditures go to institutional providers, 40% going to the nursing home industry. The few real increases in services in recent years have been for less costly alternatives to nursing home care---these will be among the services first undermined by the Administration's proposals.

THE PROPQSED CAP WILL BE A CATALYST FOR SEVERE STATE CUTBACKS IN MEDICAID

What will be the likely effects of the proposed cap? As proposed, it would reduce federal Medicaid expenditures by over one billion dollars. Under the current federal-state matching formula for Medicaid, this will mean that some $700 million in state funds will not be matched and therefore in all likelihood not budgeted or spent. The total Medicaid cut will thus approach two billion dollars. The major predictor of what states will do in response to such a cut is the actions many states proposed during the past year in response to perceived budgetary difficulties---many proposed to severely restrict eligibility and services to recipients (most of the proposals eventually did not take effect). This prediction is reenforced by a consideration of other initiatives that the Administration has proposed---such as a substantial deregulation of the health care industry---which will as discussed below serve only to exacerbate the likelihood of grievous harm to Medicaid recipients, exacerbate the inequitable distribution of health care in the country, and undercut rational cost-containment efforts towards which several states have been moving.

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*These are services which the state has historically provided, usually in state facilities, for which it recently secured Medicaid funding to help underwrite costs; examples include homes for the mentally retarded, state mental hospitals, halfway houses and the like. As indicated *infra*, provision of these services will of course be threatened by the Administration's proposal, throwing their full costs back upon state and local governments.

A. CUTBACKS IN ELIGIBILITY AND SERVICES

During the past year, in the absence of a proposed reduction in federal funding, 25 states facing budgetary problems proposed extensive cuts in Medicaid eligibility and services. For example at least four states considered dropping all "medically needy" coverage, the coverage which helps low income people from being driven into welfare eligibility by medical expenses. Eight states proposed limits on recipients' access to hospital care, and three proposed limits on physician visits. Severe restrictions were proposed on many of the so-called "optional" services---such as prescription drugs, physical therapy, dental care, mental health services, wheelchairs and medical supplies, orthopedic and vision services. New Jersey proposed dropping all optional services, a proposal other states have threatened as well. Ten states proposed dropping or severely curtailing prescription drugs, while dental care was seriously threatened in six states, vision services in five states and mental health services in seven. Three states proposed dropping wheelchairs, artificial limbs and rehabilitative therapies. Fifteen states considered imposing copayments on drugs, medical transportation and other services.* The result of the proposed Medicaid cap will assuredly be to drastically multiply the occurence and implementation of such proposals.**

B. UNDERMINING EFFORTS TO RATIONALLY CONTROL COSTS

The historically-indicated likelihood of severe eligibility and services cuts is largely caused by factors that the Administration's related proposals will exacerbate. Hospitals and nursing homes account for about 70% of the Medicaid budget. Federal law has tended to ensure them quasi-automatic cost-of-living increases due to their special reimbursement rules. While most provider groups have been able, as discussed below, to maintain a lobbying strength superior to that of recipients, these institutional providers---whose cost increases have been the primary cause for cost escalation in health care*---have enjoyed particularly formidable political clout. As a result of all these considerations, states seeking to cut back on costs have found it easiest to cut back on recipients and non-institutional, optional services.

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*Studies have shown that co-payments on ambulatory services are counter-productive, produce negative cost savings, and increase hospitalization, while deterring early and preventive care, and thus worsening the health status of the poor. Their effect is particularly noxious for the elderly whose chronic medical needs force frequent co-payments.

**What is the forseeable impact of the cap? In the 30 states which cover the medically needy, it means that 60% of the ambulatory medically needy will lose eligibiity. These are predominantly elderly individuals with chronic health needs, whose incomes are slightly above SSI levels. In the 32 states covering children in poor two parent families of unemployed, it means dropping all health care for needy children except those in single parent AFDC families. In the twelve states which cover none of these optional groups (Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Mississippi, New Nexico, South Carolina, South Dakota, Texas, and Wyoming) it likely means dropping eligibility for many persons in nursing homes. If, instead of or in addition to cutting optional eligibles, the states cut optional services, it would mean dropping home health, clinics, adult dental, and every other optional service except nursing homes and, possibly, prescription drugs. Most of these services support or constitute less costly alternatives to institutional care. Some states, however, cover few optional services and almost half the states would not be able to save the requisite funds without cutting prescription drugs or nursing homes.

Several states have, in recent years, attempted to adopt a variety of rational Medicaid cost-containment measures. These methods have ranged from improved administration and third-party collections to alternatives to institutionalization, and have sought to address escalating institutional costs as well. Thus in some states, mandatory, prospective rate-setting has held hospital rate increases at 4 percentage points lower than the rates in states without rate setting. Health planning agencies in some states have controlled hospital over-bedding and the mindless duplication of medical technology which raises the overall costs of Medicaid payments. Utilization review mechanisms in some locales have saved Medicaid and Medicare dollars by controlling medically unnecessary services. These cost containment strategies need to be strengthened; however the new administration's de-regulatory approach imperils these modest gains. At the same time that Medicaid expenditures will be reduced, controls will be lifted from their biggest cost component.

The Administration has also indicated that it may give the states power to redefine their scope of Medicaid coverage (the same "deregulation" has also been proposed for several other health and social programs as well). Recipients have not been able to match the lobbying efforts of the hospital, nursing home and other provider associations under the present, more defined framework. Mississippi for example increased the dispensing fee for pharmacists dramatically, and has continued maintain its nursing home rates at higher than private pay rates, while cutting to the bone the number of physician visits covered by the program. Kentucky is currently proposing to finance a forty cent increase in the dispensing fee to pharmacists by taking a fifty cent co-payment out of the pockets of recipients. In Pennsylvania, the state sought to drop eyeglasses and orthopedics and cut back mental health visits while granting fee increases worth $50 million to physicians and other providers.

Thus the result of the Medicaid cap, exacerbated by related Administrative proposals, will be to seriously diminish the access of the most truly needy to health care. Health care providers will retain a superior ability to get slices of the smaller Medicaid pie; as costs and fees rise, eligibility and services must decline. As indicated, these consequences are accompanied by an aborting of some promising cost containment initiatives. We face the anomalous prospect of seeing health care expenditures in general go up (due to deregulation), while expenditures for the neediest are slashed. We face a probable curtailment in alternatives to institutionalization. Home health alternatives---for which there has been increasing clamor on humane and cost-savings grounds---are significantly funded by the "optional" Medicaid services which will be among the first victims of the cap.

C. ADDITIONAL DETRIMENTAL POLICY CONSEQUENCES

A further deficiency in the Administration's Medicaid cap is that it at best freezes the current inequitable distribution of Medicaid coverage. Because the cap has no exceptions for growth in eligibles, Texas, New Mexico, Alabama and many other states will never receive any federal matching to help them to give coverage to a variety of optional Medicaid coverage groups -- the medically needy, aged, disabled, and families with incomes slightly over the AFDC or SSI categorical assistance grants, unborn children, and children in two parent families. Alaska, Nebraska, South Dakota, Wyoming and other states cover less than 40% of their poverty populations under Medicaid; while California, New York, Illinois, Massachusetts and Michigan cover 80 to 90%. Will these divergent ratios, which deprive the poor citizens of the low coverage states of their fair share of federal health expenditures, be frozen into posterity? Will Arizona's poor be frozen out of Medicaid in perpetuity while county after county in the state goes bankrupt and shuts down its health care system because earlier generations of state legislators rejected Medicaid? Will the 42% of the elderly poor and 44% of poor children currently without Medicaid be denied the opportunity to petition state legislatures for expanded federal and state coverage of their health needs?

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*The National Governor's Association recently noted: "Federal Medicare... reimbursement policies are inflationary, and contribute significantly to medical care inflation faced by the states.... Hospital costs currently are escalating at an annual rate of 18% and must be revised if Medicaid and other relatively small payors are to realize reductions in hospital expenditures." National Governors' Association, Alternative Medicaid Cost Containment Recommendations, Response to 5% Medicaid Cap Proposal. The Medicaid cap fails to address these root causes of health care costs escalation.

Such a "freeze" in the inequitable status quo is the best that could be hoped for under the cap. As indicated it will in fact represent a wholesale retreat from an equitable approach to health care and cost containment. It will be a step towards greater inequity; as the National Governor's Association has noted, the cap "will have extremely different implications for individual states, depending on economic conditions, current service coverage, and eligibility policies and the rate of increase in local medical care costs." The cap purports to simply throw health care cost back upon local payors, whose inability to support those services was a primary reason for establishing the Medicaid program.

President Reagan's proposals put the financial hazards of economic downturn on the state governments and recipients. Medicaid caseloads and spending have increased during recessions and other periods of high unemployment. States because of constitutional prohibitions against deficit spending have little capacity to absorb this spending increase. Moreover, state governments do not manage the economy and do not establish policies responsible for economic downturns. Rather this responsibility lies with President, and Congress. The cap on Medicaid spending would therefore put the states and recipients at risk for federal policy failures in managing the economy while relieving the federal government of any fiscal responsibility to remedy the human suffering caused by its failures.

We believe that Medicaid and health care cost containment, directed at the major causes of cost increases and/or waste should be not only pursued, but mandated. We also agree with public rhetoric that if budgetary cuts are to be required, they should be imposed in an equitable manner, one in which the "truly needy" would be hurt the least. The Administration's proposals fail to address either of these goals. They place the full burden of health care financing "reform" on those least able to shoulder the load.

COMMENTS ON THE APPROPRIATIONS FOR PUBLIC HEALTH SERVICE AND THE OFFICE FOR CIVIL RIGHTS

The National Health Law Program submits this testimony to be included in the hearing record. This testimony will address our concerns about the appropriations for Public Health Service Programs, specifically the Community Health Center Program, the Migrant Health Center Program and the National Health Service Corps. We also will address the specific appropriation for the Department of Health and Human Services, Office for Civil Rights.

Public Health Service Programs

The National Health Law Program opposes a 25% cut in the appropriations of the Community Health Center Program, the Migrant Health Center Program and the National Health Service Corps.

These programs have an enviable record providing high quality, cost-efficient medical care to hundreds of thousands of rural and urban Americans. They are desperately needed and should be maintained and augmented.

Geographic and Economic Barriers to Health Care

Approximately 30 million men, women and children in this country are without adequate access to medical care. Fully one-third of the nation's counties are medically underserved; in 1977, 6.3% of all rural counties had no patient care physicians whatsoever.

Nationally, we may have enough physicians, but they are poorly distributed between and within states. While some states are saturated with physicians, other states--notably New Mexico, Arizona, Alaska, North Dakota, South Dakota, Nebraska, Wisconsin, Missouri and every southern state (see attached map)--have far too few medical providers to meet their needs.

Lack of health care providers in rural America is especially severe: this area contains approximately 30% of the country's population yet is served by only 12% of the nation's physicians; over half the 1807 Health Manpower Shortage Areas (HMSAs) are located in rural areas.

The paucity of medical care providers affects all population groups. It has, however, its greatest impact on the nation's poor and minorities. Hispanics of New Mexico, Arizona, and California, Blacks of the South and urban ghettos of the northeast and west, and poor Whites of Appalachia, Maine, and the Dakotas share a similar hardship--difficulty in obtaining medical care when ill. Community clinics and NHSC providers have been a primary source of medical care for this population.

At least half of this nation's poor are not covered by Medicaid. Nor does Medicaid coverage guarantee access to medical care; low Medicaid reimbursement rates make physicians reluctant to care for program recipients. In rural America, for example, 23% of the primary care physicians will not take Medicaid recipients In addition, with drastic Medicaid cutbacks in the offing, both the number of Medicaid eligibles and providers willing to care for this population are likely to be reduced.

The Community Health Centers Program, the Migrant Health Centers Program and the National Health Service Corps were established to redress the inequitable distribution of medical care providers in this country. These programs have, in a relatively short period of time, been remarkably successful.

Community and Migrant Health Centers: Cost-Efficient, High Quality Providers

In 1974, community based health centers provided services to almost 1½ million persons. In 1979, they served over three million. During these four years, the volume of services increased 200 percent while grants for these centers increased by only 20 percent.

Numerous studies have proven that community and migrant health centers have a substantial impact on the health status of their communities: in some area they have reduced infant mortality by as much as 50% and rheumatic fever by 60%. These centers emphasize preventive services such as screening, immunizations, and prenatal care, as well as primary care to children and adults. This emphasis has resulted in reduced hospitalization rates for clinic patients by as much as 25% below the level experienced by similar populations not using the centers.

Not only do community and migrant health centers save money by reducing the need for expensive hopitalization, they provide reasonably priced medical care. Between 1974 and 1979, clinic productivity increased by 30%, while administrative costs decreased by 25%. Nationally, when all services are considered, the average cost of providing medical care to a health center patient is $32 per encounter compared to $55 per encounter per Medicaid recipient; the average cost of physician services per patient per year is $72 for a health center patient, $99 for a Medicaid recipient, $157 for the U.S. population. Health centers are also 33 to 50% less costly than hospital outpatient departments and emergency rooms.

Federally-sponsored health centers provide high quality medical care. Dr. Mildred Morehead, of the Albert Einstein School of Medicine in New York, studied the care provided by several centers between 1968 and 1976. She concluded that the centers studied provided care at least equal to and, in some instances, superior to that provided by other established providers in their neighborhoods.

Community and Migrant clinics have been successful in providing medical care for the "truly needy". Eighty percent of all center users have incomes below 150 percent of the poverty line and over 80 percent are minorities.

The National Health Service Corps: Providing Care Throughout the Nation

The National Health Service Corps is critical to this country's efforts to increase the number of medical providers in underserved areas. Corps personnel are placed in private sites in underserved communities as well as in health centers. Since its creation in 1970, the Corps has approved over 1,400 sites for Corps placements and actually placed over 900 personnel, primarily physicians. Corps physicians have provided care in every state in the Union. By 1980, 37 sites in New Mexico, 16 sites in North Dakota, 34 sites in South Dakota, 50 sites in Florida, 27 sites in Missouri, 23 sites in Oregon, 53 sites in West Virginia, 45 sites in South Carolina, 52 sites in Pennsylvania, 7 sites in New Hampshire, 4 sites in Connecticut 10 sites in Alaska and 30 sites in Wisconsin had either been staffed with National Health Service Corps personnel or been approved for staffing.

Clinics and NHSC: Working With, Not Against Private Providers

Corps physicians and community and migrant clinics do not compete with private doctors. Indeed, clinic grants are awarded and NHSC personnel sent to those areas of the country with the greatest degree of need: in many communities these programs work alongside private providers; in other communities they are the only providers of medical care for miles around.

The Centro Campesino de Salud operates nine clinics in New Mexico. These clinics are dependent on both Community and Migrant health center funds and the National Health Service Corps. Thousand of low income persons would not get medical care if federal support for these clinics was withdrawn.

In Osage Prairie Integrated Rural Health Project in southwestern Missouri, a National Health Service Corps physician and dentist work alongside private providers in a group practice to serve the community surrounding El Dorado Springs.

Covenant House in Philadelphia, Pennsylvania serves a population of 6,000 low income children teenagers and adults with the help of two Corps physicians and a nurse practitioner. There are no alternative providers to Covenant House in Philadelphia's Germantown.

A secondary benefit of the NHSC is that the program sometimes serves as a source of physicians who eventually establish private practices in underserved communities. In Marianna, Florida, for example, a Corps supported physician opened a practice of the Corps and went into private practice on his own, He stayed in Marianna, a city which had for ten years been trying to attract physicians.

Clinics and NHSC: A Source of Community Revitalization

In addition to providing medical care to communities in need the clinic programs and NHSC provide economic benefits to their communities. The placement of a center in a poor urban or rural area creates jobs and stimulates local economies through the purchase of material, supplies and services. The average health clinic in a central city employs 55 people; a rural center employs 25 people most of whom are community residents. These centers also serve as a source for on-site training and education of local residents, and, in rural areas, serve as catalysts for the development of water, sewage and transportation systems. In addition the potential productivity of the community is improved as the level of illness declines.

Community health clinics bring one last, intangible benifit to the communities in which they reside--pride. Communities have built these clinics and they are community controlled. This represents efforts by poor Americans to make better and health lives for themselves and their children. They represent what is best in America.

A 25% cut in Community Health Clinic and Migrant Clinic Programs and the NHSC would be understandable if these programs were no longer needed. But this is not the case. There are no alternatives for indigents dependent on these programs.

The National Health Service Corps, the Community Health Center Program and the Migrant Health Center Program have barely begun to fill the unmet needs in medically underserved areas. A 25% cut in appropriations for these programs will mean that hundreds of thousands of Americans will once again have no access to health care.

The Office for Civil Rights

The National Health Law Program recommends an appropriation of $31 million for the Office for Civil Rights to support a total staff of 690 persons. The budget request by the Administration is insufficient, in our judgment, to permit necessary functioning of this critical Office. Moreover, the budget requested will not even be adequate to support the proposed staffing level.

The OCR Mandate

The Office for Civil Rights is responsible for assuring compliance with the various civil rights statutes by recipients of Federal financial assistance from the Department of Health and Human Services. Approximately 825,000 entities receive Federal financial assistance from the Department. These entities include hospitals, nursing homes, day care centers, and child welfare agencies.

The overwhelming emphasis of the former Department of Health, Education and Welfare was on enforcement of civil rights statutes in an educational context. This approach left health and human services programs in a state of serious neglect. The recent history of OCR has been largely a story of attempting to catch up from this period of neglect.

Three statutes make up the bulk of OCR's work. Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of handicap. (The vast majority of the complaints that OCR receives involve allegations of discrimination against the handicapped.) Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin. The Age Discrimination Act of 1975 prohibits discrimination on the basis of age.

Inadequacy of Current Staffing Levels

The congressionally-authorized staffing level for the Office for Civil Rights is 590 persons. Because of the Carter Administration's employee reduction initiative, that ceiling was reduced to 572 persons. Now the current Administration has proposed to reduce that ceiling even further, below the current actual staffing level of 526 persons.

Three basic approaches are used to assure compliance with the civil rights laws. OCR conducts investigations of recipients when a complaint has been filed that alleges a violation of one of the statutes within OCR's jurisdiction. OCR also conducts onsite compliance reviews of recipients to evaluate compliance where it has reason to believe that violations may be occurring. OCR also provides recipients with technical assistance in the requirements of the civil rights laws and regulations to encourage voluntary compliance.

When the Department of Health, Education and Welfare was divided into the Departments of Education and Health and Human Services, the DHEW Office for Civil Rights was also divided between the two new departments. Two-thirds of the OCR staff were assigned to the new Department of Education. Only one-third were retained by the Department of Health and Human Services. This division was approved by the Office of Management and Budget on the basis that 100 persons would be added to the DHHS-OCR staff in the next budget cycle.

The 100 additional staff persons were not authorized under the continuing resolutions for Fiscal Year 1981. At the same time, the number of complaints filed with OCR exceeded Department projections by nearly 20%. These two factors combined to increase the backlog of uninvestigated complaints, decrease the number of compliance reviews, and limit the ability of OCR to expand voluntary compliance efforts. By the end of January, for example, OCR had voluntary compliance staff in only three of the ten OCR regions.

Inadequacy of Budget for Current Staff

The proposed budget for the reduced OCR staff is also inadequate to support the number of positions requested. That budget is based on figures for personnel compensation that underestimate actual personnel compensation costs by as much as 20%.

This incorrect budget assumption resulted from the split of the Department of Health, Education and Welfare. When the Department was split, it was assumed that the Office for Civil Rights in the new Department of Health and Human Services would have the same average personnel grade as the previous combined Office for Civil Rights. That assumption ignored the fact that although the Office was now much smaller, it still had to have a Director, 10 Regional Directors and appropriate senior staff. Since the average personnel grade for these positions is higher than the average grade for the Office as a whole, this increased the average personnel grade far beyond the figures set forth in the budget request.

This incorrect assumption has had drastic adverse effects on the Office for Civil Rights and its mission. Because funds allocated for personnel costs were inadequate, the Office has been forced to shift funds from such other budget categories as travel. This has further limited voluntary compliance efforts and onsite reviews.

This erroneous assumption has now been perpetuated in the current Administration's budget submission. The National Health Law Program urges the Senate Appropriations Committee to provide sufficient funds to meet personnel costs at whatever staffing level is authorized.

Needed Staffing Level

The Office for Civil Rights needs a staff of at least 815 persons to adequately perform congressional mandated and needed functions during Fiscal Year 1982. In light of the policy of fiscal restraint of this Administration, the National Health Law Program urges this Committee to appropriate sufficient funds to support 690 persons in the Office for Civil Rights. While this budget allocation will not be fully adequate, it will prevent the complaint backlog from reaching unacceptable levels while not jeopardizing performance of other needed functions.

Since the investigation of complaints is a non-discretionary responsibility of the Office, other functions must necessarily be curtailed if staffing levels are inadequate. Voluntary compliance and compliance reviews are the two areas most likely to suffer.

Voluntary compliance activities reap tremendous benefits for both recipients and beneficiaries. OCR technical assistance helps recipients understand the requirements of the laws and has greatly reduced the financial burden on recipients by suggesting less costly alternatives that will still realize the program goals. In addition, through voluntary compliance activities, beneficiaries often realize the protections of the civil rights laws that might otherwise be achieved only through the filing of a complaint or lawsuit. It is therefore an extremely cost-effective activity.

Compliance reviews are similarly cost-effective. More than three-fourths of all compliance reviews identify at least one violation and therefore result in some positive change for beneficiaries. These changes improve access for the beneficiaries of the congressional programs and thereby help realize the legislative mandate of the Department.

The National Health Law Program therefore urges this Committee to authorize a staffing level of 690 persons for the Office for Civil Rights for Fiscal Year 1982 and to appropriate sufficient funds to support this level.

STATEMENT OF FRANCES KLAFTER

Medical care of all kinds is financially out of reach of most people without some form of health insurance, public or private. We are opposed to the proposed cap on Federal funding for the Medicaid program because it would deprive millions of people in this situation of needed health care.

We are particularly concerned about the "medically needy," those people above the public assistance level whose medical bills have pushed their incomes well below the poverty level.

Who are these people who may well be among the first victims of a cap on Federal funding of Medicaid? Many are Gray Panther members, and we are well-acquainted with many others, particularly in the Washington, D. C. area, where we have joined with other citizens' groups to consistently oppose efforts to remove them from the Medicaid rolls. They include minor children in families of the working poor, people who have been financially wiped out by serious illnesses requiring expensive treatment, many elderly whose incomes will not stretch to cover their unexpected, costly health care expenses. These elderly people count on Medicaid to supplement the small portion of their health care costs covered by Medicare. This is part of their "social safety net," which the President has vowed will be left intact.

What is to become of these people if they are cut from the Medicaid rolls? Few states and localities are prepared to serve them under their medical charities program. Consider, for example, the elderly ill and disabled requiring home health care, those just above the public assistance level whose meager incomes could never cover the costs of long-term care, whether in the home or elsewhere. Many of them will, of course be forced into expensive insitutional care if they can no longer receive home health care under Medicaid. And who is to pay the bill then? Certainly they will not be able to do so themselves. We can, of course, let them die, but that is an option which we, as members of a civilized society, have rejected.

Who are these pople who would probably be among the first victims of a cap on Federal funding of Medicaid? Many of them are

Gray Panther members, and we are well-acquainted with many others, particularly in the Washington, D. C. area, where we have joined with other citizen groups to consistently oppose efforts to remove them from the Medicaid rolls. They include minor children in families of the working poor, people who have been financially wiped out by serious illnesses requiring expensive treatment, many elderly whose incomes will not stretch to cover their unexpected, costly health care expenses. These elderly people count on Medicaid to supplement the small portion of their health care costs covered by Medicare--to pay large expenses, for example, such as nursing home care or home care, and relatively small expenses, such as the cost of prescription drugs which they cannot afford and without which they perhaps cannot survive. This is part of their "social safety net," which the President has vowed will be left intact.

What is to become of these people if they are cut from the Medicaid rolls? Few states and localities are prepared to serve them under their medical charities programs. Consider, for example, the elderly ill and disabled requiring home health care, now financed in many states by the Medicaid program (and only marginally financed by the Medicare program). If they are on some form of public assistance, presumably they will, for the time being, continue to be eligible for this care. But what if they are in that unfortunnate category of people just above the public assistance level who have been impoverished by illness, whose meager incomes could never cover the requirements of long-term health care, whether in the home or elsewhere? Many of them will, of course, be forced into expensive institutional care--hospital or nursing home--where somebody will have to argue about who will pay the bill. Certainly they will not be able to do so themselves.

There is, of course, an option which no one mentions out loud, but which is implicit in the proposed Medicaid cuts--we can let them die. This is an option that we, as members of a civilized society, have rejected.

The Administration claims that the proposed budget cuts will be "equitable." But Federal programs for the poor were designed to help correct inequities--in the case of Medicaid unequal access to health care. Until the inequity this program was designed to correct has been removed, cuts in it can in no way be considered "equitable." As Vernon E. Jordan, Jr., President of the National Urban League, pointed out in a recent op. ed. article in the Washington Post (February 19): "Even modest cuts in social programs will have a devastating impact on many poor families. Pennies taken from the poor hurt more than dollars taken from the wealthy. The relatively moderate sacrifices demanded of the affluent or of corporations will be compensated for by tax cuts."

President Reagan, in presenting his proposals for his economic program to the Congress, asked citizens to speak up if they have "an alternative which offers a greater chance of balancing the budget, reducing and eliminating inflation, stimulating the creation of jobs and reducing the tax burden." Even if I were a learned economist, which I am not, I would not think of addressing all of these questions in my brief time before this subcommittee. I will only remind you of what every one already knows, and that is that an increase in defense expenditures will not do any of these things. Moreover, leading commentators express serious doubts as to whether the planned massive, inflationary increases in military spending will even enhance national security.

On the specific question of alternatives to the proposed cuts in health expenditures, we hope this subcommittee will take a thorough look at all federally funded health programs in order to determine which of them are serving to help keep the population well and which are inefficient and wasteful, and that it will not opt for indiscriminate and hasty cuts that will leave large segments of the population without needed health care, particularly preventive health care, which in the long run saves the nation many millions of health care dollars. For example, simultaneously with proposals to cut the Medicaid program, the National Health Service Corps is being virtually wiped out, despite the fact that it has been providing much needed health care in many impoverished areas, particularly to Medicaid recipients. With the curtailment of services in community health centers staffed wholly or in part by National Health Corps personnel, many patients remaining on the Medicaid rolls will be forced to turn to more expensive private doctors, often practicing in "Medicaid mills." Other patients being cut from the Medicaid rolls will be forced to go without medical care until their illnesses reach a much more expensive, critical stage, for which the public must bear the cost of treatment or let them die.

The ultimate alternative to which the country will surely some day turn, because it is the most efficient and economical way to deliver quality health care to the people, is adoption of a community-based federally funded National Health Service, as proposed in the last several sessions of Congress by Congressman Ronald V. Dellums.

Because it represents succinctly the views of the Gray Panthers on the Administration's budget proposals, I am attaching hereto a copy of a press release issued by the Gray Panthers on February 19 of this year.

Thank you for this opportunity to present the views of my organization to this subcommittee.

GRAY PANTHERS TERM REAGAN BUDGET "AGEIST"

What will kill people faster--the Soviets or the internal poisons of our own society: poverty, pollutions, and the oppression of ageism?

President Reagan's proposed budget is ageist in nature in that it threatens the well being of those segments of our population which are most vulnerable to societal ills. Those segments are the old and the young who are the least visible in their suffering. They are often disenfranchised because of age, social and economic status, and lack of mobility.

They are victims of a poisoned environment, a feeble health care system, inadequate transportation, indecent housing, poverty and social discrimination. Yet support for programs that address these problems is being cut by President Reagan with his proposed cuts in medicaid. foodstamps, welfare, educational aid programs, health programs, CETA, and social security.

His budget clearly reflects a perception of our national values: what he wants to sustain in life, and what he wants to let die by neglect. He sustains a greatly increased military while cutting programs which rob our children of the future they have a right to inherit, and rob our old people of the present and future they have earned.

The Gray Panthers know that many government programs are burdened by waste, inefficiency and duplication. We will be looking for responsible ways to remedy this situation. We will look for ways that are life-affirming. "... to measure national security solely in military terms is to ignore a threat to the national security of which Mr. Reagan seems totally unaware. It springs from the unprecedented pressures of global population increase, worldwide resource depletion and universal environmental degradation, menacing the security and stability of this and every other country". (John B. Oakes, NYT)

We will be looking critically at our fatty military budget as well as other programs which contain waste. We will be looking at ways to guarantee a safe environment, to guarantee safe renewable energy and to guarantee well-being to all of our citizens. Our strength and our defense is in the well being of our people, not in the size of our military.

SUBCOMMITTEE RECESS

Senator INOUYE. The subcommittee will stand in recess until 9:30 tomorrow when we will meet again in this room to hear testimony from public witnesses on human development and education programs of the Federal Government.

[Whereupon, at 6 p.m., Tuesday, March 17, the subcommittee was recessed, to reconvene at 9:30 a.m., Wednesday, March 18.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

WEDNESDAY, MARCH 18, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:35 a.m. in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. William Proxmire, presiding.

Present: Senators Schmitt, Abdnor, Spector, Proxmire, and Burdick.

NONDEPARTMENTAL WITNESSES

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. The subcommittee will come to order. Senator Proxmire will join us shortly and will be your principal chairman for the day and as chairman of the subcommittee I want to say for the record how much I appreciate my various colleagues helping chair what is without a doubt the most extensive set of hearings any subcommittee must hold and one person could not possibly do it by themselves and I appreciate the great assistance I have had from various members of the subcommittee.

Today the subcommittee will continue to hear testimony from public groups interested in Federal appropriations under the Labor, Health and Human Services, and Education Subcommittee banner. Most of the day we will be hearing from groups interested in appropriations for the Department of Education, but we will begin today's testimony with a panel interested in funding for the Office of Human Development Services.

Of necessity, the time allotted to outside witnesses is limited. In your testimony I hope you will give us your highest priorities for funding among the major program areas. Once we have completed the fiscal year 1982 budget, the subcommittee plans a more deliberate look at various programs under the subcommittee's jurisdiction this year in preparation for the fiscal year 1983 hearings next year.

The panel on the Office of Human Development Services will now begin and that panel consists of John A. Calhoun, assistant director of the Child Welfare League of America; Barbara Daniels, executive director of the Chaparral Home and Adoption Service of Albuquerque, N. Mex.; MaryLee Allen, director, Child Welfare, Children's Defense Fund; Al Russo, director of social services, American Federation of

State, County, and Municipal Employees; Dr. Robert Green, dean, school of social work, University of Connecticut and representing the Council on Social Work Education; and John B. Martin, legislative consultant with the National Retired Teachers Association.

Each witness, as you have been informed I believe, will be allotted 2½ minutes in this 15-minute period. Please try to stay as close to that as you can and we will use the yellow light system to alert you when there is 1 minute left in your presentation. If I might be permitted to call the witnesses out of order I'd like to exercise the chairman's prerogative and ask Barbara Daniels to begin.

It's great to have you here this morning. It's good to see you in this environment, although I'd much prefer to see you in New Mexico as you know.

Ms. DANIELS. I'm going back this afternoon. I understand snow is predicted.

Senator SCHMITT. Please go ahead.

Ms. DANIELS. I submitted written testimony and I would like to make just a few comments.

Senator SCHMITT. I would say to all of the witnesses; written testimony will be a part of our record in its entirety.

STATEMENT OF BARBARA DANIELS, EXECUTIVE DIRECTOR, CHAPARRAL HOME AND ADOPTION SERVICE, ALBUQUERQUE, N. MEX.

Ms. DANIELS. I'd like to make just a few comments, Senator, because I'm involved in directing services to people, especially children in need of homes, and I'd just like to review with you what we're doing in New Mexico.

As you know, 4 years ago we did a study to determine how many youngsters were living in their permanent homes and how many were in temporary care. This study disclosed that there were at least 1,500 children in New Mexico who were not living in any kind of permanent situation. Now for a State the size of New Mexico, this is an unusually high number of children.

This did result in our agency receiving a title XX contract through which we share the responsibility of finding homes for children with the State of New Mexico. Our agency places the infants and children up through age 5 and the State finds homes for the other children.

Now when we began doing this no baby had ever been placed directly from the hospital with adopted parents.

Because we are a small agency and we can work quickly and efficiently, the majority of the youngsters that we did place for adoption went directly from the hospital to the adopted parents.

Now because we were taking care of the small children, the State workers were able to concentrate on serving the older children, the teenagers, who needed homes. They have placed around 70 each year.

Now we hope that we could continue doing this arrangement with the title XX funding because we feel that we can do it quicker, more efficiently, and more economically.

Just for the record, we were given $60,000 of Federal money the first year and we were able to place 49 youngsters.

I see the yellow light is on and I'm going to quickly say that we also hope that we can serve unwed parents who are in need of help in planning for their unborn babies and we feel all the programs which deal with pregnant women ought to be able to interpret all of the options available to them and the reason why is because the majority of the toddlers that we are now serving were born to unwed teenagers who kept them for a short while. These youngsters then were either voluntarily released or removed by the protective services division because of abuse and neglect.

Now many of these children are enomtionally disturbed and many of them have physical problems that should have been corrected earlier and I firmly believe that with proper counseling to the parents most of these children [illegible] have been placed in adoptive homes earlier.

Senator Pr[illegible] Chairman Schmitt.

Senator Sch[illegible]ank you, Mr. Chairman. I would just ask one question, I kn[illegible] limited.

There has be[illegible] program in New Mexico and I know of similar programs nationally about baby selling. Do you have any estimate of how many babies are moved into homes on the so-called black market?

Ms. Daniels. Yes, I do. We probably place around 120 youngsters a year. I would say that the gray or black marketplaces as many as we do and this is truly unfortunate because the young women who are having the babies are not getting any kind of service and many of the couples who are adopting children through this market are people that licensed agencies like ours have rejected.

Senator Schmitt. I see. Thank you, Mr. Chairman.

Senator Proxmire. Thank you.

Our next witness is John Calhoun. Is that right? You don't look like John Calhoun.

Ms. McConnell. Contrary to what it says on the witness list, I'm not. I'm Nancy Fifield McConnell. I'm director of the Child Welfare League.

Senator Proxmire. Ms. McConnell, you have the allotted time. Go right ahead.

STATEMENT OF NANCY FIFIELD McCONNELL, DIRECTOR, CHILD WELFARE LEAGUE OF AMERICA

Ms. McConnell. Thank you. We appreciate the opportunity to testify on behalf of children in relation to the important decision this committee will make on appropriations.

While our interest extends beyond the Office of Human Development Services, today I will confine my brief remarks to OHDS programs and submit more extensive testimony for the record.

Specifically, I would like to talk to you about two programs which have already demonstrated what is an appropriate role for the Federal Government; that of supporting families and children in a cost-effective manner. These are title IV(b) child welfare services and title XX social services of the Social Security Act.

After 4 years of intensive work, last year Congress passed and the President signed into law the Adoption Assistance and Child Welfare

Act of 1980, Public Law 96–272. This is a family support bill. The law proposes major reforms in services to children with special emphasis on services to enable children to remain in their own homes or if that is not possible to find permanent homes through adoption.

In title IV(b) of the law financial incentives are offered to States to redirect child welfare programs away from foster care and toward permanent placement. This redirection not only makes good sense in human terms but also in economic terms. A demonstration project in San Mateo County, Calif., the prototype for Public Law 96–272, illustrates how the law can effect significant cost savings—$2 million was appropriated for services for 4 years on a demonstration basis with these impressive results. The number of dependent children out of home care was reduced by 33 percent and caseloads decreased by 2 percent. The average length of time a dependent child remained in out-of-home care was reduced 45 percent or 293 days. The majority of people served have remained at home or have been returned home within 24 months.

Experience in other States like Oregon and Virginia also substantiates these claims. The reforms in IV(b) are entirely dependent on the level of appropriations. Last year there was strong support for full funding for IV(b) and a continuing resolution to start this reform process.

Now, just as the system has gotten off the ground, the administration has proposed to consolidate the components of Public Law 96–272 into a social service block grant. This would completely undermine the intent of Congress to reform the foster care child system.

The Child Welfare League recommends Public Law 96–272 be protected as a system to reform child welfare services and that this committee recommend an appropriation of $220 million for fiscal year 1982 and with the appropriation advance funding for 1983.

Senator PROXMIRE. Your time is up, if you could conclude in a sentence or so.

Ms. McCONNELL. Yes; we also support the ceiling on the title XX funding which is also included in Public Law 96–272. We think this has been a responsible block-grant program for the 6 years that it's been in effect and we urge this committee not to economize in programs that would hurt children and their families.

Senator PROXMIRE. Thank you very much.

STATEMENT OF MARYLEE ALLEN, DIRECTOR, CHILD WELFARE, CHILDREN'S DEFENSE FUND

Senator PROXMIRE. Our next witness is MaryLee Allen, of the Children's Defense Fund.

Ms. ALLEN. Thank you. I am Marylee Allen, director of child welfare at the Children's Defense Fund.

The Children's Defense Fund appreciates this opportunity to testify about fiscal year 1982 funding for two programs which provide essential services for poor and homeless children which this committee has generously supported in the past. Our written testimony addresses both the Head Start and the title IV(b) child welfare services programs, although this morning I would like to appeal to you only on behalf of the 500 million children who will be addressed by the reforms and funding for the title IV(b) child welfare services program.

As Nancy McConnell indicated that for the Child Welfare League the title IV(b) program is essential to implementation of Public Law 96–272 which the Congress enacted only 8 months ago. Public Law 96–272 addresses real problems in this country's foster care system. These problems have been documented by numerous reports in a number of studies—New Mexico, California, New York, Pennsylvania—in many studies the problems have been the same.

Too many children are unnecessarily separated from their families, linger in inappropriate placements indefinitely, and often grow up in a foster care system. We are talking about real children, real children who the committee wanted to help when it approved $163.55 million for the IV(b) program for fiscal year 1981. There's Mrs. B's preschool children who entered care when the furnace of their rented home broke during a very cold winter. $250 would have fixed that furnace. There's Mrs. G's five children who enter foster homes when Mrs. G went for help. Her closest sister died in an automobile accident and she couldn't meet the daily demands of child care. There are children like Dennis Smith who at age 17 was in his 16th foster home.

Funding for the title IV(b) program will provide service to help families like Mrs. G, a homemaker, to maintain and keep her children in her home. You also have case reviews and case plans which will help children like Dennis Smith from being lost in the foster care system.

We certainly urge you as you consider funding for fiscal year 1982 to again appropriate $220 million for the IV(b) child welfare services program. These reforms are essential to change the system of foster care. They are also cost effective as the Child Welfare League has indicated, and will result in long-range cost savings for States. Thank you.

Senator PROXMIRE. Thank you, Mrs. Allen.

STATEMENT OF AL RUSSO, DIRECTOR OF SOCIAL SERVICES, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

Senator PROXMIRE. Our next witness is Al Russo, director of social services, American Federation of State, County and Municipal Employees.

Mr. RUSSO. Thank you very much, Mr. Chairman.

I appear before you this morning to summarize AFSCME's views on the critical funding levels for a number of vital human service programs during fiscal years 1981 and 1982 which may be affected by the administration's proposed reductions.

Although we have a strong commitment to all human programs designed to alleviate human need, our statement will focus on the broad area of social services, including child welfare services.

Many of the more than 1 million members of AFSCME work in social services programs at the State and local level. Each day they respond to the needs of millions of Americans for services and assistance. By far, these are persons who are poor because of marginal incomes. Some of them are working. Others are recipients of public assistance, and many rely on fixed incomes such as social security and SSI. We observe on an intimate basis each day the differences these services mean to them in stabilizing their lives and the lives of their family members as they pass through difficult stages of economic and social stress. For this reason, Mr. Chairman, AFSCME is gravely concerned about what will happen to these Americans, and indeed to our country, if funding for these social services programs is not maintained.

We wonder how the 600,000 children in day care programs—what will happen to them if day care funds are cut back. We wonder about the 500,000 children who are lingering in foster care homes and how many additional thousands will join them if funding levels are cut back.

Mr. Chairman, the President and the administration has proposed to consolidate 12 social services programs into 1 block grant and more than this they propose a 25-percent reduction. We are convinced that the proposed 25-percent reduction will have a disastrous effect both on the consumers and providers of these vital services.

For fiscal year 1981, Mr. Chairman, we would strongly recommend that the title XX social services funding level be held at $2.9 billion and $164 million for child welfare services under title IV(b). For fiscal year 1982 we would strongly recommend that title XX funding be maintained at the $3 billion funding level as authorized by Public Law 96–272 and at the $220 million level for title IV(b).

I know the time is running out, Mr. Chairman. In concluding, may I stress this point. Mr. Chairman, the administration has yet to send to Congress any of its block grant proposals. In fact, we have heard that no such proposals will be ready until late spring, too late to be implemented until late next year. We therefore urge you not to assume any savings from the block grants unless and until they are enacted. We also urge you, Mr. Chairman, not to abandon those who can least afford to help themselves by cutting these vital human services this year and in future years.

May I, Mr. Chairman, on behalf of the American Federation of State, County, and Municipal Employees, express my appreciation for affording us the opportunity to present our views.

Senator PROXMIRE. Thank you, Mr. Russo.

STATEMENT OF ROBERT GREEN, DEAN, SCHOOL OF SOCIAL WORK, UNIVERSITY OF CONNECTICUT, REPRESENTING COUNCIL ON SOCIAL WORK EDUCATION

Senator PROXMIRE. Our next witness is Dr. Robert Green, dean of the School of Social Work, University of Connecticut, speaking for the Council on Social Work Education.

Mr. GREEN. Thank you, Mr. Chairman.

I represent the Council on Social Work Education which consists of 83 graduate schools of social work and over 200 undergraduate accredited programs in social work education. Ten of those programs are in the State of Wisconsin.

I'd like to make three points if I can. While all the others have spoken rather eloquently about the need to support social services, I'd like to speak specifically about the need to support social service training and education.

In fact, the proposals of the administration will totally eliminate—totally eliminate all phases of social welfare training except in the area of aging, and in that area it will provide considerable reductions.

Social work training services moneys have been and continue to be targeted in specific areas of need as the administration has requested. The Federal role is appropriate and should be continued.

Further, over the past 2 or 3 years these programs have already absorbed a substantial cut in the area of child welfare from $8.5 million to $5.5 million; in title XX training from $110 million to $75 million; in mental health training from $175 million to $93 million; and in aging from $17 million to $12 million. These cuts have already been absorbed within the training system in this country and this system can no longer or cannot continue to absorb cuts and still maintain its integrity.

I might point out that the moneys not only are targeted toward special areas of population needing training services but also are targeted toward rural areas where there's a tremendous shortage of manpower and, for instance, in our State of Connecticut, our NIMH program provides for work training. Through the New England area the child welfare grant provides services in all six New England States and we provide full-time and part-time training in four of the New England States.

All of these training opportunities will be severely hampered and cut back if training moneys are not maintained and targeted as they have been in the past.

We recognize there's a considerable problem in relation to the budget, but we think it would be wasteful and inappropriate for the Federal role in training to disappear as these budget cutbacks are made. Thank you, Mr. Chairman.

Senator PROXMIRE. Thank you, Dr. Green.

STATEMENT OF JOHN B. MARTIN, LEGISLATIVE CONSULTANT, NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

Senator PROXMIRE. Our last witness on this panel is John B. Martin, legislative consultant, National Retired Teachers Association and the American Association of Retired Persons. Go ahead, sir.

Mr. MARTIN. Thank you, Mr. Chairman.

At the outset, I want to stress that the 12 million member National Retired Teachers Association and the American Association of Retired Persons recognize that this Congress is determined to cut Federal spending substantially. We strongly support this overall objective because inflation is the No. 1 enemy of the elderly and bringing the Federal budget into balance is one of the actions that must be taken to bring inflation under control.

We believe that each program must stand on its own feet and merits and receive careful scrutiny by the Congress. In many cases Congress may decide to reduce spending; however, some programs should not be reduced because they are cost effective and they respond to present needs.

One example is the title V senior community service employment program which enables low-income persons 55 or older who have poor employment prospects to improve their well being by helping others in the community. In view of the fact that the poverty rose sharply by nearly 500,000 among persons 55 or older in 1979, this program becomes especially important. Another increase in poverty is expected in 1980, although its dimensions are not known.

Our association believes that title V should receive at least $277.1 million requested by the administration.

Title V has been an extraordinarily effective program. About $9 out of every $10 is spent for wages and services for older Americans. Even more impressive are the results of the cost benefit analysis of the program conducted by our association. Permanently hired SCSEP workers were shown to return more per year in tax revenue than the cost in tax revenue to place a worker in the job. Every permanently hired SCSEP enrollee produced $15,000 worth of economic output under this program in retirement. It's in the Nation's best economic interest and for its older people to work by creating and expanding special employment programs for them. They are better and so are we to have them producing rather than surviving on welfare.

We also recommend that funding for training under the Older Americans Act be retained at the fiscal year 1981 level of $14 million. Our association believes it would be unwise to cut the training program, especially given the already severe shortage of adequately trained personnel.

We feel that funding for discretionary demonstration programs ought also be retained at the fiscal year 1981 level at $15 million. The argument for continued funding of title V demonstrations at the fiscal year 1981 level is compelling, especially in an era when funding for services programs may be stabilized or perhaps reduced. Demonstration programs can be effective management tools to provide for stretching limited Federal dollars.

Senator PROXMIRE. Thank you very much, sir, and I want to thank all six of you panelists. I didn't hear the first presentation in full, but I was very impressed. I think you made a fine presentation and we deeply appreciate it and it was a good record and it will be read with attention by the other members of the committee.

[The statements follow:]

STATEMENT OF BARBARA DANIELS

My name is Barbara Daniels, and I am Executive Director of Chaparral Home and Adoption Services, a private, not-for-profit, statewide agency located in Albuquerque, New Mexico. Chaparral Home and Adoption Services is a charter member agency of the National Committee For Adoption (NCFA) and I currently serve on the Board of Directors of NCFA, and am appearing on behalf of the National Committee For Adoption.

Chaparral Home and Adoption Services has functioned since 1969 as the primary independent and private social agency in New Mexico to provide confidential services to unwed parents, children and adoptive parents. My agency provides casework services to nearly 200 people annually who are seeking alternatives to problem pregnancies. 50 unmarried girls were served through Chaparral Maternity Home last year. We also offer professional social work services to couples who wish to become adoptive parents. Last year 120 children were placed in permanent homes. On October 1, 1980, we began our third year of a Title XX purchase of services contract with the New Mexico Human Services Department to find homes for 50 infants and 15 toddlers during the next fiscal year. In addition to the Title XX contract, Chaparral Adoption Services serves at least 60 more children annually. We work in partnership with the State Department, which last year found 78 homes for older children and children who had been in foster care homes. We are sharing home-finding responsibilities with the State Department so that more of New Mexico's children will be adopted sooner as infants, and thereby prevent more of New Mexico's children from being placed in foster care for too long. Along with State and Federal revenues, we are also sharing in the funding of these important services to children and their families. We receive funding through adoptive parent's fees, sliding scale fees charged to unmarried girls who are able to pay, and other private charitable contributions.

The National Committee For Adoption was formally established in June of last year, and is a national, voluntary membership organization for agencies and individuals who are working for infant adoption as a positive institution that builds families, that promotes permanent homes for children, and that is an option for young, single, and troubled parents. The National Committee and its members have been working to make acceptable the Federal

"Model State Adoption Act" mandated by Title II of the Child Abuse legislation, P.L. 95-266. NCFA believes that the version proposed by the HEW Advisory Panel and published in the Federal Register in February, 1980, should be stopped and are monitoring similar activities at the State level. On March 19 - 20, NCFA is sponsoring an invitational conference on "The Image of Maternity Homes Today", where representatives of agencies serving pregnant adolescents can meet to discuss the current challenges and successes of serving unmarried girls in a residential, comprehensive services setting. NCFA also provides services to agencies serving infertile couples who are considering agency adoption as a way to build their families.

I am pleased to appear before this Subcommittee, but also am somewhat awed by the responsibility I feel in presenting to you in very brief remarks, NCFA's priorities for children. I know that it is this Subcommittee's responsibility to review the billions of Federal dollars in programs--which are matched by billions more in State and private dollars--which currently exist because of perceived needs of this country's most vulnerable people. And while you want to be responsive to the "mandate for change" President Reagan has presented in his Federal Budget for 1982, you have the responsibility to provide adequate Federal funds for those in need of social services, health care, education and jobs.

We, therefore, are not going to give you "bottom line" figures for specific appropriations, but instead want to ask you to keep our priorities in mind as you set the appropriations levels for FY 1982.

We recommend that the Subcommittee consider protecting two groups of children as decisions are made about where cuts in HHS Office of Human Development Services' human services could be made:

o The Federal government's budget should protect the thousands of infants of young, troubled or single parents who are unable or unwilling to give their babies proper care. For many of these infants, adoption may be their best chance.

o The Federal government's budget should protect the thousands of young girls--and young boys--who discover that they are going to have a baby and don't know what to do. For many of these young children-as-parents, making a plan of adoption for their child would be the best plan.

It is for these two groups of children that many agencies are offering professional social work services so that the rights and interests of biological parents, children and adoptive parents may be best protected and served. Many Federal funding sources contribute to the sources of revenues used by agencies to provide counseling, medical and residential care to unmarried parents; to provide foster care and health services to babies who are not yet legally freed for adoption; and to provide adoption counseling and approval for prospective adoptive couples. The programs being recommended by President Reagan to be consolidated into the social services block grant are the Federal funding sources used by many agencies for services promoting adoption including Title XX, Title IV-B, AFDC Foster Care and Adoption Assistance for families who adopt "special needs" children.

The National Committee For Adoption believes--and my work with young pregnant girls bears this out--that...both the social and economic problems which this country's children and families are experiencing could be prevented if adoption is presented as a positive alternative to adolescent parenthood, single parenthood, or abortion for thousands of our young women. Here are a few reasons why:

-- Nearly half of government expenditures through Aid to Families with Dependent Children (AFDC) is for households with women who were teenagers when their first child was born. ("The Status of Children, Youth and Families", 1979 ACYF/OHDS Publication)

-- The Wall Street Journal in a series on welfare cited increasing numbers of teen-age mothers are keeping their children rather than placing them for adoption as one reason why more people are on AFDC. A 15 year old pregnant girl, eligible for $216 per month from AFDC payments, is quoted, "In a way, I still feel the baby would be better off in a foster home, but I have to at least give it a try". (Wall Street Journal, 2/19 and 2/23/81)

-- According to studies of the foster care system, too many young parents have "given it a try" and have had to rely upon the foster care system to care for their infants. In a study of the New York City foster care system, it was reported that 22.7% of all children in the system came into care as infants. These children, who would not during infancy be considered "hard to place", are the very children who develop mental and physical "special needs" as they become older and remain in foster care longer, requiring more expensive special adoption services and subsidies for parents willing to provide them with permanent homes. ("Children Discharged from Foster Care", Professor David Fanshel, Child Welfare, September/October 1978)

Not only would the infants be better off if placed for adoption sooner, but also would so many of today's young women. Those young women should be provided the opportunities to reassess their situations, continue their education and training, and prepare definite plans for a self-sufficient future. The overwhelming responsibilities of parenthood too ofter diminish the young parent's chances for accomplishing this future which is productive for the individual and society.

In the past, the Federal government has done very little to promote adoption as one option for a pregnant adolescent. President Reagan has recommended that the $10 million adolescent pregnancy program be consolidated into a preventive health services block grant. The National Committee For Adoption does not believe that all the problems related to adolescent pregnancy can be addressed under the rubric of "preventive health services". We strongly encourage this Subcommittee to be mindful of the need for adequate attention to adolescent pregnancy and adoption activities, such as Title XX and Title IV-B which provide funds for maternity home care, social services counseling and planning for adoption. Increased attention and appropriations for these services will result in decreasing the costs of numerous benefit programs, including AFDC, Medicaid, and Foster Care.

We also want to bring to the attention of this Subcommittee our very serious concerns about a Federally funded activity, the development of a "Model State Adoption Act", which has had a modest dollar cost to the Federal government, but which has caused grave emotional and financial costs for a number of concerned parents, adopted persons, experts and agencies. A proposed Model State Adoption Act was published on February 15, 1980 in the Federal Register which received comments from 17,000 people (including petitions) and the overwhelming majority of those who wrote were distressed by the proposals recommended for infant adoption and services to unmarried parents in the model law. In a June 4, 1980 letter to the former Secretary of HHS, Senators Tower, Helms, Humphrey and Hatch stated that "...the Model Adoption Panel exceeded the scope of its authority and ignored the intent of Congress, thereby creating a number of new problems--social as well as legal--which will make it more difficult to free children for adoptive placement". The four major provisions, recommended by the Model Adoption Panel and rejected by the public and dozens of Senators and Representatives, including Senator Cranston and Congressman Simon, the Chairmen of the Authorizing Subcommittees responsible for the Act during the 96th Congress are:

1) requiring automatic opening at the request of an adoptee of the age of 18 of confidential birth records, court records, and adoption agency records;
2) confers upon all biological fathers of children born out of wedlock, without appropriate distinction, the right to veto the adoption of the child upon mere proof of paternity;
3) sets less stringent standards for the placement of children by unlicensed intermediairies than by licensed child-placing agencies; and
4) gives parents the right to revoke relinquishments which have not been obtained through fraud, duress, or undue influence.

NCFA believes that these provisions, if enacted nationwide, would be harmful to the past, present and future of adoption in this country. Just as we believe the Federal government needs to take a more pro-active stand on behalf of infant adoption as an alternative for unplanned pregnancies, so we believe the Federal government should not be providing financial support for the development of so-called "model" guidelines for States which set up new barriers for adoption.

This Model Act has been funded as part of the $5 million appropriations for Adoption Opportunities, Title II of the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978, during fiscal years 1980 and 1981. The Carter Administration estimated that approximately $80,000 is needed to complete, publish for comment, and finalize a Model State Adoption Act, and included this as a supplemental request for 1981 appropriations.

We are hopeful that Secretary Schweiker, and his Assistant Secretary of the Office of Human Development Services-Designate, Dorcas Hardy, will be responsive to the Congressional and public comment and publish a final Model State Adoption Act which is limited to eliminating the barriers to adoption of children with special needs. Finally, we hope that this Subcommittee, in its oversight role, will encourage the Department to limit any further expenditure of Title II funds on to those subjects dealing with adoptions for special needs children. We hope you direct particular attention to the other funds available under this title, especially those provided to the Regional Adoption Resource Centers, so that they are not used to provide technical assistance on or otherwise promote those portions of the Advisory Panel's proposed Model Act which have received Congressional criticism.

Thank you for the opportunity to testify before the Subcommittee.

STATEMENT OF JOHN A. CALHOUN, ASSISTANT EXECUTIVE DIRECTOR, CHILD WELFARE LEAGUE OF AMERICA

Mr. Chairman, I am John A. Calhoun, Assistant Executive Director of the Child Welfare League of America and Director of the League's Center for Governmental Affairs. I wish to thank you for this opportunity to testify on behalf of children in relation to the important decisions you are about to make in recommending appropriations for the Department of Health and Human Services. The appropriations you are considering will affect all of America's children and families and are closely tied to the programs and services of the Child Welfare League of America.

The Child Welfare League of America was established in 1920 and is the only national voluntary membership and standard setting organization for child welfare agencies in the United States. Our agencies provide adoption services, day care, day treatment, foster care, institutional care, maternity home care, protective services, residential treatment, runaway and shelter care, group home service, homemaker service, emergency shelter care, services for children in their own homes and services for children and families under stress. The League is a privately supported organization comprised of 400 child welfare agencies in North America whose efforts are directed to the improvement of care and services for children. The agencies affiliated with the League include all religious groups, as well as non-sectarian public and private non-profit agencies. Through a separate division, the Child Welfare League also represents 1,600 child care agencies affiliated with 30 State Child Care Associations in the League's Office of Regional, Provincial and State Child Care Associations.

Our interest in the appropriations for the Department of Health and Human Services extends beyond the Office of Human Development Services, but today I will confine my remarks to OHDS programs and provide written testimony for the Record on our concerns related to health services programs.

We are at a critical moment in history. The new Administration and the Congress interpret the November election results as a mandate to make radical changes in the role of the Federal government. President Reagan wishes to restore us to economic health. He wishes to release again the spirit of volunteerism. He wishes to trim bureaucratic fat and avoid duplication of effort. With these goals the League is in full accord. We need economic health and do not wish to preside over the dividing of an ever-diminishing economic pie for our programs.

The question is how one can respond to the November voters and still maintain critical services. And there are additional questions: is the safety net under the neediest? We do not think it is. Are state and local governments able to assume the fiscal and administrative responsibilities thrust upon them? We do not think they are. Will these proposals support families? We do not think that they will. Thus, three major policy objectives of the new Administration will not be met by some of the proposals before you. Finally, we have serious doubts whether the citizens of this country intended that children be the primary targets of budget cuts.

The proposals for a new federalism emerged in the 1950's and again in the early 1970's, as state and local governments demanded more control over money coming into their jurisdictions. What is new is that instead of responding to state and local concerns by proposing a combination of funding possibilities, structuring some local control and some with Federal supervision, the proposals that have recently emerged almost entirely eliminate the responsibility of the Federal government for the care and protection of the most valuable, most vulnerable of the population, the nation's children.

The issue is not control or supervision. The issue is that children are falling through the "safety net", abused and neglected, homeless and truly poor children are targeted as needing federal assistance. The President has spoken of a return to state and local control. In theory this is sound, but in point of fact most if not all states are ill-equipped to assume the financial and administrative burdens associated with these proposals.

We are surprised to find that the consolidation proposals do not reflect a critical evaluation of which programs work in a block grant approach and which do not; what impact consolidation will have on children and families. We do not stand absolutely opposed to block granting. There are efficiencies. But children must be protected.

Specifically, I would like to talk to you about two programs which already have demonstrated what is an appropriate role for the Federal government, supporting children and families in a cost effective manner -- Title IV-B of the Social Security Act (child welfare services) and Title XX of the Social Security Act (social services).

TITLE IV-B OF THE SOCIAL SECURITY ACT -- CHILD WELFARE SERVICES

Until 1980 the federal government made a modest contribution to states through Title IV-B of the Social Security Act to protect and promote the welfare of children. The financial contribution by the states has been about 93 percent of the total expenditures. After four years of intensive work, Congress last year passed and the President signed into law, the Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272. This is a family support bill. This law proposes major reforms in services to children with special emphasis on services to enable children to remain in their own homes or, if that is not possible, to find permanent homes through adoption. Financial incentives are offered to states to redirect child welfare programs away from foster care and toward permanent placement. The effort was dramatically bi-partisan: 402-2 was the vote in the House; it was unanimous in the Senate.

Let's look at what the law means in human terms. An abused child was given treatment in a local medical center for cigarette burns on the soles of her feet. The father was arrested, and convicted of child abuse, and is now on probation. As a result of this he has lost his job. He and his wife are now separated. His wife now receives AFDC for her other two children. He receives unemployment insurance. The abused child is in foster care placement. No work is being done with the family. Each are supported in their individual situations. Nothing is being done to bring them together. Note carefully in this example where all the services and money lie: with the individual; outside the sphere of home and family. The social costs for foster care, unemployment insurance and welfare payments are astronomical. The human costs and permanent damage are even higher. And this is only for one, single family. Given the family focus mandate of P.L. 96-272, the response of the judicial and social service systems would have been radically different. New "family based" programs are springing up all over the country and the initial results are staggeringly successful. In this case, the father would have been assigned by the court to Parents Anonymous, where in a weekly meeting with other abusing parents, he would have had the opportunity to share his thoughts, problems and fears. He and his wife would receive marriage counseling. The child and the father would have the opportunity to see if reunion was possible. This represents the wave of the future. The new law, P.L. 96-272, has returned us to sensible, more natural, and permanent forms of care. Please do not turn the clock back now.

The reforms of P.L. 96-272 are directly tied to increased appropriations for Title IV-B services. In order for states to receive a share of increased Federal child welfare services funds, states are now required to: --conduct an inventory of children who have been in foster care for over 6 months; --implement a statewide information system on children in foster care; --implement a case review system for each child in foster care, designed to achieve placement in the least restrictive setting in close proximity to home and with procedural safeguards to children, parents and care providers; --implement a service program designed to assist children, where possible to return to their own homes.

Additionally, P.L. 96-272 establishes a new Title IV-E to provide some federal funds for a national adoption subsidy program to assist families willing to adopt hard-to-place children with special needs. If P.L. 96-272 is fully implemented, foster care maintenance now included in Title IV-A would be moved to the new Title IV-E with a cap on Federal funds as an added incentive to states to move children out of foster care. The status of these new IV-E programs appears uncertain at present since they are mandated to be "triggered" by child welfare services appropriation levels of $164 million for FY 1981 and advance funding levels of $220 million for FY 1982 and $266 million for FY 1983 and 1984.

The reforms of P.L. 96-272 grew out of substantial work by interested organizations, experts, child advocates, researchers, and Congress. A Second Chance for Families, published by the Child Welfare League of America in 1976, provided documentation that intensive family services either prevent or shorten foster care placements. An investment of $500,000 resulted in cost savings of approximately $2 million and shortened the average child's foster home placement by 24 days.

A demonstration project in San Mateo County, California, which was the prototype for P.L. 96-272, adds significant credibility to the argument that the law can effect significant cost savings. Two million dollars was appropriated for services for four years on a demonstration basis to implement provisions similar to the requirements in P.L. 96-272 with these impressive results:

1. The number of dependent children in out-of-home care was reduced by 33 percent statewide, and caseloads decreased by about 2 percent.
2. The average length of time a dependent child remained in out-of-home care was reduced by 45 percent or 293 days.
3. The majority of children served have remained at home or have been returned home within 24 months.

Passage of P.L. 96-272, the Adoption Assistance and Child Welfare Act, has been a top priority of the Child Welfare League, and we have high hopes that it will continue to be implemented so that homeless children will be permanently placed. Inclusion of child welfare services in a larger block grant would completely undermine the intent of Congress to reform the foster care system and see that the nation's dependent, neglected, abandoned or abused children find permanent homes. If Title IV-B child welfare services are included in a larger block grant, there is no guarantee that the required amount of money will be available at the state level to trigger the reforms; and, in fact, the preliminary proposal for funding of the block grant projects a 25 percent reduction which would place federal funds for child welfare services far below the trigger level. These children would fall out of the safety net. Likewise, accountability is an essential part of the new law, and accountability would be lost in the proposed block grant approach. If the Congress is serious about reforming child welfare services, then Title IV-B cannot be part of a consolidation plan. The complexities of the law and the interrelationship of the reforms and available funds make this an inappropriate candidate for consolidation.

The Child Welfare League of America recommends that the Congress separate the components of P.L. 96-272, Adoption Assistance and Child Welfare Services, from the proposed social services block grant and maintain its unique identity as a system to reform child welfare services. We therefore recommend that Congress appropriate $220 million for FY 1982 for child welfare services and continue the impetus for reform.

TITLE XX OF THE SOCIAL SECURITY ACT -- SOCIAL SERVICES

Title XX is a five-year old social services block grant program, originally funded at $2.5 billion with the states contributing supplementary funds of approximately $1.5 billion. For FY 1981 the appropriation was raised to $2.9 billion, providing the incentive for states to continue to increase state funding. Of the total Title XX program expenditures, 62 percent targets children. The attached pie chart shows the breakdown of services provided with Title XX funds. A further breakdown of individual services demonstrates why Title XX is cost effective and keeps families together:

Service	Estimated Number of People Served[1]
Day Care Service for Children	838,884
Day Care Services for Adults	64,211
Family Planning	1,395,780
Education, Employment and Training	801,638
Family Counseling	1,208,564
Substitute Care for Children and Youth	352,006
Health and Mental Health Services	1,303,130

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[1] TECHNICAL NOTES: Summaries and Characteristics of States' Title XX social Services Plans for FY 1979, U.S. Department of Health, Education and Welfare, Office of the Assistant Secretary for Planning and Evaluation.

The Child Welfare League has been involved with Title XX since its inception. Title XX enables agencies to expand services and provide care for increased numbers of disadvantaged children by contracting with the state agency to provide services with Title XX funds. The "purchase of service" concept has created a new partnership between public agencies and private agencies to deliver needed, high quality services to children.

Title XX has been cited by many as the model for the Administration's block grant proposals. If this is true, it is important to consider why Title XX has worked, what its limitations are, and what will be the impact on Title XX of further consolidation into an even larger social services block grant program.

Title XX has certain safeguards and accountability features which have promoted effective implementation: broad goals with flexibility; requirements that in each geographical area of a state at least one service must be directed to each of the goals; a public review (voluntary citizen participation) process; a state plan; reporting requirements; a 25 percent matching requirement; an earmark for child day care; and requirements that services provided with Title XX funds be reasonably in accord with recognized standards of national standard setting organizations. It is, in short, the ideal Republican bill.

In 1980, several changes were made in Title XX programs by P.L. 96-272. While the changes did not substantively alter the program, for the first time in five years funding for Title XX was changed by statute: the new law raises the funding ceiling through 1985 ($2.7 billion for FY 1980; $2.9 billion for FY 1981; $3 billion for FY 1982; $3.1 billion for FY 1983; $3.2 billion for FY 1984; and $3.3 billion for FY 1985). This was considered to be minimal funding for fulfilling the Title XX mandate.

Placing Title XX (already a large block grant) in a larger block grant program would further dilute and politicize the program, with more and more service constituencies competing for reduced funds. Title XX has a strong five-year history built on procedures for planning and accountability. This is the program which keeps families off welfare and offers the services necessary to maintaining or establishing self-sufficiency. "Self-sufficiency" is certainly a goal of the new Administration. **We strongly recommend that Title XX remain a separate block grant program.**

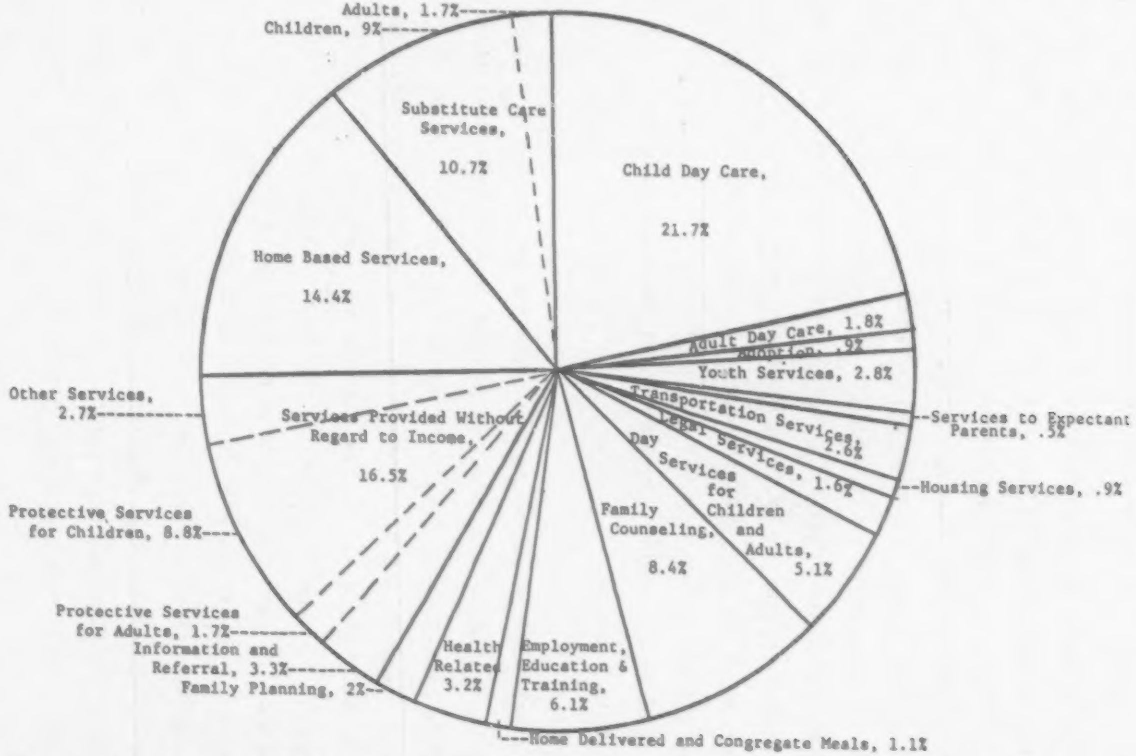
Congress may be forced to repeal Title XX, P.L. 96-272 and Titles IV-B and IV-E, or at the very least, amend the statutes and rescind the important features which have led to self-sufficiency and cost-effective change for children and their families. And the funding will be severely curtailed. A 25 percent reduction of social welfare programs with removal of maintenance-of-effort will mean a total cut of 50 percent. Thousands of national programs, forced to reduce services by 50 percent will close.

Day care centers will close; mothers will be forced onto welfare; abused children will remain unprotected and untreated; the reform family bill will languish; children will remain homeless; shelters will close; families willing to adopt children will not be connected with these homeless children; and ironically, the cry for categorical services to protect and serve children will begin again.

We understand the need for economizing and block granting. But the twin goals of local control and reduction by 25 percent of social service funding collide with the other goals of the administration -- providing a safety net for the most needy, and support for the American family. In the collision, children will be the victims. By shortchanging them now, we shortchange the next generation -- our future.

Thank you.

ESTIMATED TITLE XX EXPENDITURES, FY 79



Source: Technical Notes: Summaries and Characteristics of States' Title XX Social Services Plans for FY 1979, U.S. Department of Health, Education and Welfare, Office of the Assistant Secretary for Planning and Evaluation.

STATEMENT OF MARYLEE ALLEN

I am MaryLee Allen, Director of Child Welfare at the Children's Defense Fund. The Children's Defense Fund (CDF) is a national public charity created in 1973 to provide a systematic voice to improve the lives of children and place their needs higher on our nation's public policy agenda. CDF has issued a number of reports on major problems facing large numbers of children in the areas of child welfare, mental health, education and child care, and seeks to address these problems through the monitoring of federal and state policies and practices, litigation, and public education. In addition, we work with parents and state and local community groups committed to furthering children's interests.

Thank you for providing this opportunity for me to testify today about Fiscal Year 1982 appropriations for several programs of great significance for poor, homeless, and handicapped children in this country. We are grateful for the way you have responded to the needs of these children in the past, and ask you now to continue your support for the Head Start Program and the Title IV-B Child Welfare Services Program. We urge you to support President Reagan's request for $950 million in Fiscal Year 1982 for the Head Start Program, and to include $220 million for the Title IV-B Child Welfare Services Program, a program that is essential to implementation of P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, which was enacted only 8 months ago.

HEAD START

Head Start is a federally funded child development program for economically disadvantaged three to five-year-old children. During its 15 years of existence, Head Start has provided medical, dental, nutrition, educational, social, and mental health services to 7.5 million children and their families, including over 700,000 handicapped children.

In the last ten years researchers have found that Head Start really works -- and that it is cost-effective. For example, Head Start graduates are far less likley than non-Head Start graduates to have to repeat a grade or to require expensive special education. Furthermore, in the past school year 80 percent of all Head Start children received thorough medical examinations, and 91 percent of those received needed follow-up medical attention, which likely prevented subsequent major health problems.

Given Head Start's proven success, CDF hopes that this Committee will support President Reagan's request for $950 million in Fiscal Year 1982. The vast majority of the $130 million increase over the program's Fiscal Year 1981 level will be used to help offset the effects of inflation on current programs. None of the funds will be used for expansion. Head Start will continue to serve only 20 percent of the eligible children. Yet we support the Administration's decision to improve the program before expanding it.

TITLE IV-B CHILD WELFARE SERVICES PROGRAM

The Title IV-B Child Welfare Services Program is a crucial component of P.L. 96-272, The Adoption Assistance and Child Welfare Act of 1980, which became law on June 17, 1980, after years of careful analysis and debate by the Congress. The Act is intended to stimulate systemic child welfare reforms and long-range cost savings to benefit the over half million homeless children in this county, and the thousands entering care each month. It amended the two major federal child welfare programs, the IV-B Child Welfare Services Program and the AFDC Foster Care Program, so as to redirect current federal fiscal incentives away from out-of-home care and toward alternatives to out-of-home care: services to keep families together and to reunite children who must be placed with their families, and subsidies to assist with the adoption of children with special needs, including mental, physical or emotional handicaps. It also provides fiscal incentives to the states to implement procedural safeguards to protect children and insure dollars are well spent. These protections include requirements for case plans, information systems and periodic case reviews to ensure that children enter care only when necessary, are placed appropriately, provided quality care, and reviewed periodically.

P.L. 96-272 was enacted to address problems evident in foster care systems across the county. National studies such as CDF's Children Without Homes, and studies in individual states--New Mexico, Oregon, Pennsylvania, Connecticut, Mississippi, and New York, to name only a few, have documented that too many of the 500,000 children in foster care were separated unnecessarily from their families without efforts first being made to provide services to prevent placements. Alternative services such as a homemaker to assist a grieving parent with four young children meet the daily demands of child care, or a day treatment program to give parents of a handicapped child some relief from the demands of daily care for the child too frequently don't exist. Further, once children get into care they often are placed inappropriately, in overly restrictive settings. And they grow up in care, without services to reunite them with their families or to ensure they are provided new permanent families through adoption.

Increased funding for the Title IV-B Child Welfare Services program is crucial to implementation of the child welfare reforms in P.L. 96-272, and the development of the alternatives to placement just described. Appropriation levels for the IV-B program provide triggers in P.L. 96-272 for implementation of the protections and preventive and reunification service programs. Thus, sufficient funding for the IV-B program is essential in attempting to redirect current funding patterns which encourage costly out-of-home care and discourage the development of alternatives to placement.

These alternatives, when put in place, have been shown not only to help children, but to be cost-effective as well. Long range cost savings will be realized when the costs of implementing preventive and reunification services and adoption subsidy programs are contrasted with the costs of leaving a child in foster care until age 18. Projects across the country prove that alternative services do prevent prolonged foster care. Let me share several examples with you.

> Washington -- In 1977 Washington passed legislation mandating crisis intervention services for "families in severe conflict." About 40 percent of these services were delivered to the entire family in their own home. State officials estimate that the legislation and an increased emphasis on finding permanent homes for children saved the state about $2 million in a six-month period alone.

> New York -- In 1976 the Lower East Side Family Union in New York City provided alternative services to over 400 families,

> half of whom were identified as high risk families whose children were likely to enter foster care. Yet over the course of the year, foster placements only had to be obtained for children in 11 of the families and in six of them the children returned home in less than two months.
>
> Oregon -- A permanency planning effort in Oregon which provided intensive services to 509 children who had been in foster care a year or longer and were believed to have little chance of being reunited with their families, resulted in 29 percent of the children being returned to their families, and 36 percent being adopted. During the three year period of the project it was estimated that over $1 million in direct room and board payments were saved.
>
> Pennsylvania -- An "Agressive Adoption" program instituted in Cumberland County resulted in the total number of children in foster care being cut in half in a five-year period, with an estimated savings to the county of over $600,000, when contrasted with direct expenditures for maintaining those children in care.
>
> California -- Data from the Los Angeles County Department of Adoptions reported a savings of $1.5 million during the first 12 months of placement for 570 children, and a projected savings of $17.5 million when costs were contrasted with what it would cost to maintain these children in foster care until age 18.

P.L. 96-272 also provides assurances that increased IV-B funds will provide quality care. Expenditures under the program are subject to your annual scrutiny. And states are required to arrange for a "periodic and independently conducted audit" of the program at least once every three years.

The law also directs how IV-B funds will be spent. They can not be used for room and board and are targetted instead for more cost-effective services and protections. Further, in the future states will be required to have the procedural safeguards, as well as preventive and reunification services in place to be eligible for more than a limited amount of the IV-B funding.

CDF strongly urges the Committee to recommend $220 million for the Title IV-B Child Welfare Services Program for Fiscal Year 1982. This amount is the minimum necessary to turn around current child welfare policies which encourage costly, often inappropriate out-of-home care for these children.

In the event President Reagan's proposed social services block grant comes before the Committee, we urge you to recommend that the IV-B and IV-E child welfare, foster care and adoption assistance programs be maintained as separate programs, and that they be funded at a combined total of $550 million.

The IV-B and IV-E programs are part of P.L. 96-272 which was passed by the Congress less than eight months ago to help maintain families and to ensure the more cost-effective use of funds. The IV-B and IV-E child welfare, foster care and adoption assistance programs should be maintained as separate programs and P.L. 96-272, which would otherwise be repealed, given a chance to work.

STATEMENT OF AL RUSSO

THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES (AFSCME) APPRECIATES THE OPPORTUNITY TO SUBMIT OUR VIEWS AND RECOMMENDATIONS ON THE CRITICAL MATTER OF FUNDING LEVELS DURING FISCAL YEARS 1981 AND 1982 FOR A NUMBER OF VITAL HUMAN SERVICES PROGRAMS, WHICH MAY BE AFFECTED BY THE ADMINISTRATION'S PROPOSED REDUCTIONS. ALTHOUGH WE HAVE A STRONG COMMITMENT TO ALL PROGRAMS DESIGNED TO ALLEVIATE HUMAN NEED, OUR STATEMENT WILL FOCUS ON THE BROAD AREA OF SOCIAL SERVICES, INCLUDING CHILD WELFARE SERVICES.

TRADITIONALLY, AFSCME HAS SUPPORTED THE ESTABLISHMENT AND EXPANSION OF THESE PROGRAMS. WE BELIEVE THAT, AS A NATION, WE MUST BE SENSITIVE AND RESPONSIVE TO HUMAN NEED. WE BELIEVE THAT WHATEVER ASSISTANCE IS NEEDED MUST BE PROVIDED IN A MANNER THAT PRESERVES HUMAN DIGNITY AND THAT IS INTENDED TO ENCOURAGE SELF-SUPPORT AND INDEPENDENCE.

MANY OF THE MORE THAN ONE MILLION MEMBERS OF AFSCME WORK IN SOCIAL SERVICES PROGRAMS AT THE STATE AND LOCAL LEVEL. THEY RESPOND EACH DAY TO THE NEEDS OF MILLIONS OF AMERICANS FOR SERVICES AND ASSISTANCE. THE PROGRAM RECIPIENTS ARE POOR BECAUSE OF MARGINAL INCOMES, OR NO INCOME AT ALL. SOME OF THEM ARE WORKING, OTHERS ARE RECIPIENTS OF PUBLIC ASSISTANCE, AND MANY RELY ON FIXED INCOMES FROM SUCH PROGRAMS AS SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME (SSI).

THE PROGRAMS ALSO ASSIST CHILDREN AND ADULTS WHO ARE VICTIMS OF ABUSE, NEGLECT, AND EXPLOITATION. THEY ARE THE YOUNG AND THE OLD WHO ARE TRAUMATIZED BY HOMELESSNESS, ISOLATION, AND DESPAIR. IN SHORT, THEY ARE THE ONES AMONG US WHO NEED A HELPING HAND ALONG THE WAY.

AFSCME MEMBERS OBSERVE ON AN INTIMATE BASIS THE DIFFERENCES THESE SERVICES MEAN TO THEM IN STABILIZING THEIR LIVES AS THEY PASS THROUGH DIFFICULT STAGES OF ECONOMIC AND SOCIAL STRESS. IT IS FOR THIS REASON THAT WE ARE GRAVELY CONCERNED ABOUT WHAT WILL HAPPEN TO THOSE AMERICANS -- AND TO OUR COUNTRY -- IF THE FUNDING LEVELS FOR THESE SOCIAL SERVICES PROGRAMS ARE NOT PROPERLY MAINTAINED.

WE WONDER HOW MANY WORKING MOTHERS OF THE 600,000 CHILDREN WHOSE DAY CARE COSTS ARE CURRENTLY FUNDED BY TITLE XX DOLLARS WILL BE FORCED TO LEAVE WORK AND TO RELY ON AFDC (AID TO FAMILIES WITH DEPENDENT CHILDREN) BECAUSE OF SEVERE CUTS IN DAY CARE FUNDS THAT REDUCE SLOTS AND FORCE THE CLOSURE OR CONSOLIDATION OF DAY CARE CENTERS.

WE ARE DISTRESSED THAT MANY OF OUR ELDERLY CITIZENS WHO ARE ABLE TO REMAIN IN THEIR OWN HOMES BECAUSE OF THE TITLE XX-FUNDED SERVICES WILL BE DUMPED INTO INSTITUTIONAL PLACEMENTS BECAUSE OF THE LOSS OF FEDERAL SOCIAL SERVICES DOLLARS RESULTING FROM A REDUCTION OR WITHDRAWAL OF THESE SERVICES.

AND WE PONDER WITH CONCERN HOW MANY CHILDREN WILL BE ADDED TO THE 500,000 ALREADY LINGERING IN FOSTER CARE BECAUSE THE PROTECTIVE SERVICES THEY NEED ARE NO LONGER AVAILABLE TO THEM AS THE RESULT OF THE REDUCTION IN FEDERAL SPENDING FOR SOCIAL SERVICES, AND OTHER PROPOSED REDUCTIONS IN AFDC, FOOD STAMPS, CHILD NUTRITION, UNEMPLOYMENT INSURANCE, CETA JOBS, AND ENERGY ASSISTANCE FOR LOW INCOME FAMILIES.

ON FEBRUARY 18, 1981, THE PRESIDENT PROPOSED IN HIS "PROGRAM FOR ECONOMIC RECOVERY" A CONSOLIDATION OF APPROXIMATELY 40 SOCIAL, HEALTH, LEGAL, AND COMMUNITY SERVICES PROGRAMS, CURRENTLY FUNDED AT A LEVEL OF $9 BILLION, INTO ONE OR MORE BLOCK GRANTS. A 25 PERCENT REDUCTION IN FEDERAL FUNDING WOULD BE IMPOSED. THIS WOULD REPRESENT A CUT OF $2.2 BILLION IN FY '82.

HE INDICATED THAT THE BLOCK GRANT APPROACH WILL PERMIT STATES TO PLAN AND COORDINATE THEIR OWN SERVICE PROGRAMS WITH A SUBSTANTIAL REDUCTION IN FEDERAL RULES, REGULATIONS, DIRECTION, AND MONITORING. STATES WOULD ESTABLISH THEIR OWN PRIORITIES AND EXERCISE PROGRAM CONTROL OVER RESOURCES PROVIDED TO LOCALITIES AND NON-PROFIT ORGANIZATIONS. THE BLOCK GRANT PROPOSAL WOULD ELIMINATE, IN THE ADMINISTRATION'S VIEW, WASTE AND INEFFICIENCY CAUSED BY PERCEIVED OVERLAPPING AND DUPLICATION OF SERVICES UNDER THE CURRENT CATEGORICAL GRANT PROGRAMS.

THE ADMINISTRATION NOW PROPOSES TO ESTABLISH FOUR SMALLER BLOCK GRANTS, ONE OF WHICH WILL BE A SOCIAL SERVICES BLOCK GRANT. IT WOULD INCLUDE CHILD WELFARE SERVICES (TITLE IV-B), ADOPTION ASSISTANCE AND FOSTER CARE (TITLE IV-E), SOCIAL SERVICES (TITLE XX) AND EIGHT OTHER PROGRAMS INCLUDING VOCATIONAL REHABILITATION SERVICES, DEVELOPMENTAL DISABILITIES, MENTAL HEALTH, AND MOST OF THE PROGRAMS NOW IN THE COMMUNITY SERVICES ADMINISTRATION. A 25 PERCENT ACROSS-THE-BOARD REDUCTION IN FEDERAL FUNDING WILL BE IMPOSED.

AFSCME IS TROUBLED BY PROPOSALS THAT ABANDON CATEGORICAL SOCIAL SERVICES PROGRAMS IN EXCHANGE FOR A BLOCK GRANT APPROACH. THE LAWS THAT ESTABLISHED THE CATEGORICAL PROGRAMS REQUIRE DESIGNATED FEDERAL DEPARTMENTS TO HOLD THE STATES RESPONSIBLE FOR THEIR PROPER ADMINISTRATION TO MAKE CERTAIN THAT THE FUNDS APPROPRIATED ARE SPENT FOR THE PURPOSES INTENDED. THIS HAS MEANT, OF COURSE, SUCH THINGS AS STATE PLANS, FEDERAL REGULATIONS AND MONITORING. DESPITE THE CONTROVERSY OVER THE FEDERAL ROLE, THE FACT IS THAT THE PROGRAMS ARE DOING THE JOB THE CONGRESS INTENDED.

WITH THE REMOVAL OF THE CRUCIAL ELEMENT OF ACCOUNTABILITY AND FEDERAL RESPONSIBILITY FOR MONITORING AND OVERSIGHT, THERE IS REAL DANGER THAT SOME OF THE SERVICE PROGRAMS WILL BE ABOLISHED OR REDUCED AS STATES ALLOCATE THE BLOCK GRANT DOLLARS ACCORDING TO THEIR OWN PRIORITIES. IT WILL BE EXCEEDINGLY DIFFICULT TO AVOID POLITICIZING THE ESTABLISHING OF PRIORITIES.

WE ARE CONVINCED THAT THE PROPOSED 25 PERCENT REDUCTION IN THE CURRENT LEVEL OF FEDERAL FUNDING FOR THE PROGRAMS THAT WILL GO INTO THE SOCIAL SERVICES BLOCK GRANT WILL HAVE A DISASTROUS AFFECT BOTH ON THE CONSUMERS AND PROVIDERS OF THESE VITAL SERVICES. IN THESE TIMES OF BUDGET SHORTFALLS, STATE AND LOCAL GOVERNMENTS SIMPLY CANNOT REACH DOWN TO FIND ADDITIONAL FUNDS. THEREFORE, SUCH CRITICAL SERVICES AS CHILD DAY CARE, HOMEMAKER SERVICES, PROTECTIVE SERVICES TO CHILDREN AND ADULTS, FOSTER CARE, AND FAMILY PLANNING WILL BE REDUCED OR ABOLISHED. FEW STATES TODAY ARE FAILING TO SPEND THEIR ALLOCATIONS UNDER THE CURRENT $2.9 BILLION TITLE XX SOCIAL SERVICES CEILING. INDEED, MANY OF THEM ARE FINANCIALLY STRAPPED IN PROVIDING SOCIAL SERVICES THAT ARE NOT REIMBURSEABLE UNDER TITLE XX BECAUSE OF THE CAP. IF THIS REDUCTION IS INSTITUTED, SOCIAL SERVICES AND STAFF WILL HAVE TO BE CUT BACK.

WE WOULD REFER THE COMMITTEE'S ATTENTION TO THE ATTACHMENT TO THIS STATEMENT. IT WAS WRITTEN BY MS. LINDA GREGORY, BUSINESS AGENT, AFSCME DISTRICT COUNCIL 57, REDWOOD CITY, CALIFORNIA. IN FACTUAL AND REALISTIC TERMS, IT INDICATES WHAT HAS HAPPENED TO THE DELIVERY OF SOCIAL SERVICES IN THE STATE OF CALIFORNIA AS THE RESULT OF PROPOSITION 13, AND WHAT MAY FURTHER HAPPEN IF THE PROPOSED 25 PERCENT CUT IN SOCIAL SERVICES IS ENACTED.

AFSCME RECOMMENDS THAT THE LEVEL OF FUNDING FOR TITLE XX SOCIAL SERVICES DURING THE CURRENT YEAR (FY'81) BE HELD AT $2.9 BILLION AND AT $164 MILLION FOR CHILD WELFARE SERVICES UNDER TITLE IV-B.

FOR FISCAL YEAR 1982, WE RECOMMEND THAT TITLE XX FUNDING BE MAINTAINED AT A $3 BILLION LEVEL. AS THE COMMITTEE KNOWS, PUBLIC LAW 96-272 AUTHORIZES A $100 MILLION INCREASE FOR SOCIAL SERVICES UNDER TITLE XX FOR THE NEXT THREE YEARS, BEGINNING IN FY'82. IT ALSO AUTHORIZES AN INCREASE IN TITLE IV-B FUNDS FROM $164 MILLION TO $220 MILLION IN FY'82. WE URGE THAT THESE FUNDING LEVELS FOR IV-B BE RETAINED.

MOREOVER, WE STRONGLY RECOMMEND THAT CHILD WELFARE SERVICES AND ADOPTION ASSISTANCE AND FOSTER CARE MAINTENANCE UNDER THE NEW TITLE IV-E BE MAINTAINED AS SEPARATE AND DISTINCT PROGRAMS. MONTHS OF INTENSIVE WORK AND EFFORT WENT INTO PUBLIC LAW 96-272, THE ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980. ITS BASIC PURPOSE IS TO PROVIDE NATIONAL DIRECTION AND FINANCIAL INCENTIVES TO STATES TO BRING ABOUT LONG OVERDUE REFORMS IN A CHILD WELFARE SYSTEM THAT HAS ENCOURAGED FAMILY BREAK-UP AND LONG-TERM, COSTLY SUBSTITUTE CARE FOR CHILDREN. WITH THE INK HARDLY DRY ON THIS LAW, IT IS NOW PROPOSED TO LUMP THESE CRUCIAL SERVICES ALONG WITH NINE OTHER PROGRAMS INTO THE SOCIAL SERVICES BLOCK GRANT. THIS ACTION WILL WIPE OUT THE STRONG FEDERAL LEADERSHIP MANDATED BY THE LAW. IT WILL RESULT IN STATES CONTINUING TO PERMIT CHILDREN TO LANGUISH IN FOSTER CARE, TO FAIL TO PROVIDE THE PREVENTIVE SERVICES THAT ARE ESSENTIAL IN ORDER TO AVOID REMOVING CHILDREN WHO ARE THE VICTIMS OF ABUSE AND NEGLECT FROM THEIR HOMES, AND TO DENY THE OPPORTUNITY FOR ADOPTION TO CHILDREN WITH SPECIAL NEEDS. BEYOND ALL THIS, WE WILL LOSE THE OPPORTUNITY TO REDUCE FOSTER CARE COSTS BY $4 BILLION OVER THE NEXT FIVE YEARS, AS ESTIMATED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

IN CONCLUDING, MR. CHAIRMAN, WE WOULD LIKE TO POINT OUT THAT THE ADMINISTRATION HAS YET TO SEND TO CONGRESS ANY OF ITS BLOCK GRANT PROPOSALS. IN FACT, WE HAVE HEARD THAT NO SUCH PROPOSALS WILL BE READY UNTIL LATE SPRING -- TOO LATE TO BE IMPLEMENTED UNTIL LATE NEXT YEAR. AFSCME, THEREFORE, URGES THE COMMITTEE NOT TO ASSUME ANY SAVINGS FROM THE BLOCK GRANTS UNLESS AND UNTIL THEY ARE ENACTED. WE ALSO URGE YOU NOT TO ABANDON THOSE WHO CAN LEAST AFFORD TO HELP THEMSELVES BY CUTTING THESE VITAL HUMAN SERVICES PROGRAMS THIS YEAR.

BACKGROUND

In order to adequately discuss the effect of cuts proposed in social service and health programs, it is really necessary to give some historical background for present programs and service levels. It is necessary because it is apparent from press reports that proposals for cuts as drastic as 20-35% have been made with the assumption that present service levels are rich, that programs are rife with overlap and duplication, and that services are available to many who are neither needy nor at risk.

And, finally, there seems to be little awareness of what concrete services are being provided, or that services are scarcely "social" at all anymore, but rather end-of-the-line crisis intervention - alternatives to hospitals, institutional placement, nursing homes or the morgue. If the social service and health programs largely financed by Federal funding and administered at the state and county level were ever characterized by bureaucratic expansionism or bountiful liberal good works, that situation is nowhere to be found in California in 1981.

Our examples will be drawn from California's San Francisco Bay Area, and care will be taken to indicate where such examples may not be applicable to other parts of the state or country.

Ten years ago, social services to individuals and families were provided on a virtually unlimited basis, so long as counties (or states, where the States actually administered the programs) provided their required match to the funding from the Federal government. Some counties and states established and supported larger and more varied service programs than others, and the services were provided by a variety of agencies - most through the states' or counties' own workers, some through contracts with private and private non-profit agencies in the communities.

Most services were provided to individuals or families who received public assistance of one type or another. Aside from a few specialized work units or non-profit agencies who might provide family planning, adoption or other highly technical services, social workers usually had "generalized" assignments and there was a high premium placed on "prevention"- of child or adult abuse, neglect, malnutrition, institutionalization, school problems, disability or the worsening of disability.

Social workers were usually stationed in geographical "district" offices, close to the client population, and when they worked with a family on, for instance, employment possibilities for an AFDC mother, could pick up and deal with planning for child care, for the care of a retarded child, for the treatment of the serious illness of an elderly relative living in the home, planning for the adoption of an unwanted child, etc. Certainly, problems could be seen and followed for a great many poor families which might otherwise become serious or life-threatening.

It should be noted that this period was also characterized by the Federal government not counting as a "social service" the provision of the in-home supportive services and attendant care which allowed the very ill and disabled or the frail elderly to remain out of institutions. Where these services were needed by impoverished applicants, they were paid for out of the same public assistance money provided by the Federal government (with local match) that paid for the client's assistance grants under ATD (Aid to the Totally Disabled) or OAS (Old Age Security) programs, in fact they wereconsidered part of the client's grant. This changed when the administration of ATD and OAS was federalized into the Supplemental Security Income (SSI) program; at that time the responsibility (and cost) of assessing the need for attendant or homemaker care remained back with the other "service" responsibilities of the states and counties funded under Title XX of the Social Security Act, but to that was added the enormous cost of the actual homemaker and attendant care itself.

The greatest impact, however, on reduction in service levels was felt with the consolidation of most service programs wholly or partially funded by Federal money into Title XX of the Social Security Act, and, most important, the placing of a nation wide ceiling on Title XX funds. With attendant care and homemaker services, so necessary to prevent even costlier institutionalization, now coming out of the same Title XX money as services to abused and neglected children, hospital discharge planning forthe poor and very ill, protective services for the financially and physically abused elderly, day care and foster home licensing and recruitment, and assistance to the retarded and chronic schizophrenic persons now released into the community after a lifetime of institutionalization, service levels began to be reduced immediately. Further, deeper reductions were needed in the other service programs as the need for attendant and in-home supportive services grew and because the nationwide "pot" of money for all Title XX services remained the same for a number of years, unaugmented by any allowance for inflation.

At the same time, demands for certain kinds of services were increasing. An aging population and an increase in alcoholism rates required more adult protective services as police and hospitals referred to social service agencies citizens for whom no one would accept responsibility; and deinstitutionalization programs added thousands of the mentally disabled to this group.

Still increasing rates of family breakup, urbanization, unemployment rates, plus more thorough reporting of child neglect and physical and sexual abuse cases have meant greater demand on child protective services, adoption and court-related services for children who have been abandonded, foster care and children's shelters.

The protective services were and are provided without regard to income, because abuse occurs at all income levels and neither the rich nor the poor are self-policing in their treatment of the young or the old.

With the pressure to provide services so urgent and with constrictions and real-dollar reductions in financial support from Title XX, the states and counties were forced to abandon the concept of "prevention" where such had been a goal; no longer could the unwed mother receive early intervention and adoption counseling or help with learning parental skills. She would finally be seen if and when her child was reported as neglected or actually abused. The older adult with an alcohol problem would be more likely to be seen when Organic Brain Syndrome had taken its toll and financial resources were spent, because caseload pressures began to allow intake on only the most urgent cases.

The effects of inflation caused cutbacks by attrition, layoffs and cancellation of service contracts. In the Bay Area, San Mateo County, for example, lost 20% of its service staff to layoffs in 1976, two years before Proposition 13. Services were pulled back from a general decentralized "district" availability to a centralized crisis only concept. Even though the County has been for several years the pilot county for a state funded project providing a good variety of services to families with an abused child (the Family Protection Act) in order to reunite families, stop abuse and prevent costly institutional placements, it still can take action on only half the cases referred to it--those where abuse is clear and present and damage to the child has already been done.

The state budget drastically reduced by the effects of Proposition 13 and Proposition 4, California cannot now hope to meet the need for social services which are only appropriately provided by government. The clients now served are not shoppers or consumers of services. They are either barely able or unable to take any action on their own behalf and their only alternative resource. is usually the local police agency from which they have very likely been referred. Other common referral sources are hospital emergency rooms, landlords who find tenants unconscious in their own filth, schools, and worried neighbors.

POSSIBLE EFFECTS OF PROPOSED CUTS

The cuts proposed in Title XX, IV B and E, CETA, any reductions in revenue sharing, developmental disability assistance, the WIC program and other related services will fall on the matrix described above, not on a fat bureaucracy or on greedy systems-sophisticates. They will fall on children, the elderly and the disabled. Agencies, now unable to provide other than emergency services, will be forced to spend 20-35 % fewer hours and workers over the same and increasing caseloads, choosing between cases like:

A five year old boy is unable to awaken his mother, who is unconscious from a suicide attempt with sleeping pills several hours ago. He calls on a neighbor for help; she phones the police, who contact the 24-hour Children's Protective Services Worker. She is presently in the emergency room of the County Hospital with a child whose injuries are being photographed for the court, and when she is able to place the injured child in an emergency foster home, she responds and finds the neighbor with the five year old and his three year old sister, who was also in the home at the time of the mother's suicide attempt. The home is filthy. She phones a Family Care Worker (available only in this county because of the demonstration Family Protection Act project) who spends the night with the children and cleans the home. Arrangements are made the next day to place the children with the mother's sister, who works and cannot care for the children
The Family Protection Act team works together with the mother, who is released from the hospital to continuing treatment on an outpatient basis, to arrange ongoing services like the Parental Stress Hotline, and protective day care for her children if necessary. This case turns out well. Without the Family Protection Act, which pays for the 24 hour crisis workers, the family care workers, training of local police agencies and the protective or respite day care, the case would have been seen hours (more likely days) later by the social service agency. With cuts in Title XX, IVB and IVE, the family might not get any services at all, with the mother returning to a situation so difficult for her that her suicide attempts would eventually succeed, leaving two older hard-to-place children to life in a succession of foster homes, fewer and fewer of which will be available even as a last worst alternative. For, unfortunately, foster care and children's shelters depend largely on these Federal funds for their support, also.

A twelve year old retarded girl named May becomes withdrawn at school, and after weeks of periodically missing school and quiet persistence by the school nurse, confesses that her father has been forcing her to have sexual intercourse with him - she indicates that her father has been doing the same thing with her sister. The school nurse calls the police and the CPS worker for help.

A four year old girl is in the emergency ward of the County Hospital. She has multiple lacerations and contusions, cigarette burns on her hands, and her hair has been pulled so hard that her scalp has separated in several places from her skull. A petition must be filed in the court to make this child a ward of the court and arrangements must be made for appropriate care for her. If she is permanently separated from her parents, she will need help in finding an adoptive home, which an adoption subsidy may assist; if she is ever returned to her home, there will need to be intensive supervision by a social worker of the child in the home and help for the parents. All are services which will be less available with the phasing out of the Family Protection Act project, even less available with any cut in the Federal funds for these purposes.

The mother and stepfather of a little girl, 6, and her brother, 28 months old, are well known to the Children's Protective Services Workers by reason of their furtive offers, from time to time, to relinquish their children for adoption. These offers usually followed lengthy periods of foster home placement after the children had been virtually abandoned to the Social Services Department with the statement " we can't cope with the kids and might harm them." Always, just prior to formal relinquishment the mother has turned up and half-heartedly taken the children back. She and the stepfather have steadfastly refused any assistance with developing parental skills and now after several more weeks of leaving the children with a sister (who does not want them permanently) call the CPS worker and indicate they want to finally sign the papers to give up the children and wish nothing more to do with them. Will the CPS worker "pick up the little girl at school and the boy at the day care center and tell them the news?" The CPS worker does this, omitting the news for now, and places the children temporarily with a good foster mother. At the meeting to discuss relinquishment, the stepfather asks if perhaps they can "get any money for relinquishing the children." These children are frightened, withdrawn, and the little girl has begun wetting the bed after many years of being dry. Time has to be available for even such simple acts as meeting with the parents to help decide the future of these children, time which will be much less available under any reduced Federal effort toward such services.

Lest it appear that only dramatic instances have been chosen to exemplify the workloads making up present service programs, let us only assure you that there are no more "filler" cases in the protective services. The people who actually "make it" to a worker for service are in serious, unfortunately dramatic trouble, frequently involving definite physical evidence of abuse. The people who, right now, need services and are not getting them, the slightly "quieter" cases are like these:

A teenaged unwed mother who is suspected by her mother of amphetamine abuse. She doesn't sleep enough, keep her medical appointments, physically care for herself , and is unwilling to take part in any program for parenthood preparation or possible adoption of her unborn child. With no time and no district worker to provide long term outreach to this young woman, she is a likely candidate for premature birth of a low birth-weight baby, child neglect, and the juvenile and adult court system. The WIC program is the only help she has accepted, and all that presently protects her and her baby - it will be cut under the present administration proposal, leaving Sarah completely vulnerable, her baby even more so.

Seventeen year old Betty has two children, aged 18 and 9 months. She lives in a motel with her children and five men who appear to be illegal aliens. Betty comes to the attention of the CPS worker when she brings her 9 month old child to the emergency room with respiratory problems. She told the examining physician that her boyfriend drank and was sometimes abusive to her 18 month old. The physician was concerned about the living situation; however, when no real physical evidence of abuse could be found, CPS had to close the case, and Betty is still living in the motel. Ten years ago, she could have been assisted by a district social worker, who could have followed the case even though abuse was not yet physically evident. Now her only resource, the Public Health Nurse, will have fewer resources like Family Planning services and WIC with which to assist Betty if Federal service cuts become reality.

In Adult Protective Services, the stories are much the same, and the choices just as difficult right now, even before any cuts in Federal support for these programs. It does no good to complain that neighbors, relatives, and abusing spouses should "shape up" and take their share of responsibility for the neglected and battered- given the social isolation in which most people live, and the fact that indifferent or abusive people don't turn themselves in, the authoritative intervention and assistance of Federally mandated and locally administered social service agencies are truly necessary, and irreplaceable - not duplicated by any other resource:

An elderly woman is reported to APS by a bank teller who says the woman has fallen down drunk in the bank and does not seem to know where she is. After detoxification at an alcoholism facility, she is found to have moderate Organic Brain Syndrome, but does not want to be institutionalized (she has run away from several institutional placements in the past). The APS worker intervenes with the woman's landlord and the supermarket near her home, and they agree to help her when she becomes confused about paying rent, etc. In this way, the woman is maintained in her home for three more years, after which she trusts the APS worker enough to try a nursing home required by her deteriorating physical condition.

An young man is reported to be sleeping and comatose in a large drainpipe in the local hobo jungle - the call comes in the APS from the police in that city because the hobo jungle is suspected of being a haven for arsonists and the young man's life may be in danger. The APS worker gets the young man to a hospital, where he indicates that he is waiting for admission to the VA hospital. Terminally ill, he has been thrown from a freight train and now has more injuries. The APS worker intervenes with the VA hospital and secures earlier admission for the young man; while he waits the APS worker assists him in securing housing and food.

The emergency room at the County Hospital reports an elderly woman with moderate chronic problems has been "dumped" there by her nephew and his wife as they head into the Sierras for the weekend. The woman is very upset and has become disoriented - she cannot go back home because she depends on her nephew and his wife; they have taken the keys and have threatened to leave her permanently if she complains any more. Investigation by the CPS worker indicates that they have systematically taken her savings and jewelry in exchange for their hostile and sometimes violent "care" of her in her old age. One of the commonest problems reported to APS is this type of "arrangement" between a helpless old person and a relative or other person who has found a victim -

things go fairly smoothly until the older person's faculties begin to slip even slightly, then the relative or "friend" move in on the money and property and either insitutionalize or virtually imprison the old person.

A disabled SSI recipient in a nursing home reports she is being left in wet and soiled clothing in her bed for hours. She, like many SSI recipients and over half of the residents in nursing homes, has no relatives to care for her welfare. The APS worker contacts the State licensing board; he also has the patient moved to another facility so that there will be no danger of reprisals at this one.

If Federal financial support for social programs is reduced or eliminated - support for services like adult and children's protective services, child care, information and referral, in-home supportive services and attendant care, discharge planning, WIC, family planning, developmental disabilities assistance, CETA, revenue sharing, unemployment compensation and other "social" programs, the impact on the population which appears and reappears in these examples will be staggering. Caseloads for workers who intervene in the problems of the yound, the elderly and the disabled will be at least 30% higher, forcing more brutal choices than are already being made. Rather that working on a nationwide plan like the Family Protection Act, which through more and more specialized services to abusinve families has kept families together and saved much of the enormous cost of foster homes and institutional placement, the effect will be to cut remaining crisis services further than the effects of the past ten years combined, and in addition, to cut the lifeline when no services exist: support for foster homes and insitutions.

For the most part, any corresponding "economic growth" has no beneficial effect on the handicapped, the elderly or the bedridden who now depend on social service programs to either stay out of more costly accommodations in institutions or to be safe within those institutions. It has only slight effect on the future for those children who are now having to wait for protection from violent or sexually abusive parents until the abuse shows on their faces.

Perhaps it's the word "social" in social services that's keeping these proposed cuts from being viewed clearly for the damage they will really cause. It's health we're talking about, health and life for the people now being served; there's nothing social about it. The longer a child or an elderly or handicapped person waits for the services we've discussed, the surer that permanent physical psychiatric and financial damage will occur in their situations, and the more likely that the expense of dealing with their problems will increase. The fewer crisis intervention and support services available, the more likely that law enforcement costs will increase for what are now called social services - this, at a time when law enforcement resources are needed badly for the real work they perform, the prevention of crime.

We believe that what will be cut if the administration's proposal is enacted is health, survival and hope for those presently being served by social service agencies, not duplication or waste. For only the basic services dealing with health and survival are left.

STATEMENT OF DR. ROBERT GREEN

Mr. Chairman and members of the Subcommittee, I am Dr. Robert Green, Dean of the School of Social Work at the University of Connecticut, Greater Hartford Campus, West Hartford, Connecticut. I am appearing today on behalf of the Council on

Social Work Education, an organization composed of 83 graduate schools of social work and over 200 undergraduate programs for social work in leading colleges and universities across the country. Over 40,000 students are enrolled in these programs. They are taught by 4,000 faculty members. In addition to educational institutions, there are 4,800 members of the Council, including voluntary and public national, state and local social welfare agencies and related organizations, faculty members, and individuals concerned with social work education.

At the outset, Mr. Chairman, permit me to express our appreciation to this Committee for its consistent commitment to the provision of quality social services to our people in need -- and to the training of qualified personnel to administer those services. I assure you that CSWE and its members recognize the difficult task which this Committee and the Congress face in the coming months in addressing serious economic problems. However, due to the economic situation, there is a continuing and growing need to provide trained, professional personnel in all fields of social services. We firmly believe that quality education and training of human service personnel who are involved in the delivery of social services is and ought to be a high priority -- budgetary and otherwise -- for all Americans.

Mr. Chairman, before proceeding to individual discussions of some of the leading training programs, let me make a few general observations on the situation as we see it respecting President Reagan's proposal to consolidate all social services programs and activities into a block grant to the states. The consolidation of child welfare and Title XX training funds with child welfare, Title XX and other service funds, together with a 25% cut in the Federal contribution, will result in the virtual elimination of training activity. Over the last two years, we have already seen sharp reductions in appropriations for training in many program areas -- not just in inflated dollar terms but also in terms of actual dollars. In all other areas -- mental health, health and aging -- some Federal responsibility for trained personnel is retained. Yet, none will be in the equally difficult and professional child welfare and social services field. A study of 25 state child welfare programs and a study of local services in Alameda County, California, have each indicated the need and importance for trained personnel in the child welfare field.

The new Administration has emphasized time and again that Federal dollars should be targeted in areas of demonstrated, genuine need, particularly in the human services area. We totally agree with that general philosophy. There is no room for waste and extravagance. However, we also believe that appropriations for training in the social services and mental health fields are not support of a general nature, but are by definition targeted support aimed at those in need. Funds for training are targeted for program areas where there is a shortage of professional social workers and other professionals such as child welfare, aging and mental health workers. As a result, we feel that the "need factor" and targeting in the area of training in social services have been fully met. The new Mental Health Systems Act specifically establishes need for all mental health disciplines.

Mr. Chairman, I would like now to comment on several parts of the fiscal 1982 budget which affect the education of human service professionals.

1. Title XX (State and Local) Training

We support continuation of the fiscal 1981 appropriation of $75,000,000, which was, incidentally, also the fiscal 1980 amount. Especially with the enactment in the last Congress of comprehensive child welfare and adoption assistance legislation (P.L. 96-272), the need for state and local training is greater than in the past -- for instance, in the area of family services. These funds are used for in-service and short-term training, for teaching grants to educational institutions, and for educational leave. Direct grants to schools aid the development of curriculum, classroom instruction, and related field experience. All states participate in this program which supports education and training of professionals to administer and provide social services in state social service agencies and private non-profit organizations. Several hundred thousand people are trained each year, to varying extents, in clinical, field, and academic settings.

2. Child Welfare Training

CSWE requests an appropriation of $5.6 million, the current fiscal 1981 figure, which is down from $7.5 million in fiscal 1980 and from $8.1 million in fiscal 1979. Grants in this category go to institutions of higher education to train workers in the field of child welfare. Program objectives include graduate and undergraduate traineeship grants for students pursuing a career in child welfare, teaching grants to schools for faculty and curriculum development, and grants for regional child welfare training centers. Fiscal 1981 funds will provide approximately 610 traineeships (with 60 grants to individual students), 67 teaching grants, and 11 training center grants. Funds are divided about equally among these three areas.

The field of child welfare is badly in need of trained professionals to deal with the growing problems of abused, neglected, or delinquent children and their families. Problems in the program areas of foster care and adoptions are well known. Inadequately educated and trained staff have been found to be a major reason for these problems.

The enactment last year of the Child Welfare and Adoption Assistance Act is a major step in the area of applying solutions where problems and need exist. For example, states are now required to establish programs to provide family services to prevent costly foster care placements. They are further required either to maintain children in their natural homes or to place them in appropriate adoptive settings. These major new initiatives to prevent inappropriate institutional care demand changes in public and private service agencies, which in turn require additional education and training of staff.

3. Mental Health Training

We support an appropriation of $11 million, the same as for fiscal 1981, for this program which supports clinical and research training through grants to universities through the National Institute of Mental Health. The program helps insure an adequate supply and distribution of mental health service providers. The clinical training and education program funds efforts to train mental health personnel, including psychologists and psychiatrists. New training and development models are also provided for, where necessary, as are research efforts on mental health issues.

The Mental Health Systems Act of 1980 is a Congressional recognition of the need to improve and expand upon services to those requiring mental health care. Successful implementation of that Act will require higher numbers of trained, professional personnel with special treatment skills.

Under current NIMH guidelines, clinical training grants are not used for general education programs, but rather for programs centered on certain key priorities such as direct preparation for work with underserved groups and with understaffed facilities, training general health care providers in mental health skills (along with training mental health specialists to work more closely with health care generalists), and training in preventive techniques.

4. Aging Training

CSWE endorses an appropriation at the fiscal 1981 level of $14 million, subject to reauthorization. Funds in this area are used to train personnel to plan for and to provide services for our elderly. Activities include manpower policy development in all programs serving the elderly, career preparation for those entering the field of aging services and for those currently serving the elderly, and training and technical assistance to state and area agency personnel and service providers.

Training functions for state and area workers include in-service training for staff, advisors, and volunteers; curriculum and instructional materials development; and professional placement of graduates.

5. Miscellaneous

CSWE also supports funding for other existing training programs such as alcoholism services, health care delivery, health planning, AFDC, rehabilitation, and maternal and child health at current FY 1981 levels and without rescissions. All of these areas have been reduced in the past 3 years by more than 10%. In addition to the programs previously discussed in detail, each of these programs is an essential part of the overall health and social services efforts of our nation. Here too, we need a qualified cadre of professionals to administer and carry out the services needed and deserved by many of our fellow citizens.

Mr. Chairman, we thank you for the opportunity to be with you today and we commend our views to the attention and consideration of you and your Committee.

STATEMENT OF JOHN MARTIN

Mr. Chairman and Members of the Subcommittee on Labor, Health and Human Services, and Education, my name is John Martin and I am a Legislative Consultant with the National Retired Teachers Association and the American Association of Retired Persons and a former U.S. Commissioner on Aging. I appreciate the opportunity to testify before the Subcommittee this morning. I realize that your time is limited. Consequently, I shall make my presentation brief.

At the outset, I want to stress that our Associations fully recognize that the 97th Congress is determined to reduce overall federal spending substantially. We strongly support this objective because we believe that federal spending must be controlled and the federal budget brought into balance as an important step in reducing inflation. All age groups have felt the harsh effect of inflation in one form or another in recent years. Older Americans, however, have been especially hard hit, primarily because many are struggling on limited incomes.

Our Associations believe that every item in the budget must be carefully scrutinized by Congress. In many cases Congress may decide that it is desirable to reduce overall spending for programs in the fiscal year 1982 budget. However, some programs clearly should not be reduced because: they are very cost effective; they respond to a vital national need; or they may help to offset other public program expenditures which are costlier in the long run.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

One program meeting all of these criteria is the Title V Senior Community Service Employment Program (SCSEP). Title V enables low-income persons 55 or older to improve their economic well-being, while helping others in their communities by providing a wide range of needed services in hospitals, schools, neighborhoods, and elsewhere.

Such a program becomes all the more important now because poverty is on the rise among elderly Americans. In 1979, poverty increased by almost 500,000 in the case of persons age 55 or older. Although Census Bureau figures are not available for 1980, many authorities expect another sizable jump in poverty for older persons because inflation continued at a double-digit pace at the same time that unemployment remained high.

Title V has been a very well administered program. It has been free of fraud and abuse. About nine out of every ten dollars for Title V is spent on wages, fringe benefits, and related services for older persons participating in the program.

Moreover, SCSEP makes good economic sense. A detailed analysis by the Associations found that, after an average period of less than a year - during which time the worker was being trained on the job and paid out of program funds - the worker was likely to be hired permanently for the job and paid by the employer. Since these older workers would have received SSI and food stamps had it not been for Title V, it was calculated that the two assistance programs saved $24 for every month an SCSEP worker remained employed. Further calculations showed that a permanently hired SCSEP worker returned $1,039 more per year in tax revenue to all units of government than it cost in tax revenue to place the worker in a job. In addition, every permanently hired SCSEP enrollee produced $15,400 worth of economic output while in the program and after permanent hiring.

This cost-benefit analysis clearly illustrates the success of the Title V program and demonstrates that it is in the nation's economic best interest to encourage older persons to work by creating and expanding special employment programs for them.

The need to expand Title V is very compelling. A major increase would clearly be justified, given the performance of the program and the great needs to be met. However, our Associations are simply urging that the program should at least be continued at the $277.1 million recommended funding level.

Title V has served the elderly, local communities, and the Nation well. The assessment from newspapers throughout the country - as well as the communities being served - is that the program has been extraordinarily effective. For these reasons, we reaffirm that the program should at least be funded at $277.1 million.

TRAINING

In addition, we are calling upon the Subcommittee to fund Title IV training and discretionary demonstrations under the Older Americans Act at the fiscal 1981 levels.

Training was already cut by almost 18 percent last year, from $17 million in fiscal 1980 to $14 million in 1981.

We do not believe that it is sound policy to reduce funds further for training personnel to deliver vital social services which enable older persons to live independently in their own communities, especially when the Congress has boosted funds substantially for social services in recent years.

Quite clearly, one of the most serious problems confronting the entire field of aging is the critical shortage of suitably trained personnel to provide the essential services that older persons need so desperately. Any reduction in training funds would, in our judgment, be counterproductive and only intensify an already serious problem.

At the same time, we recognize that it is simply not possible to fund Title IV training to respond fully to the need for more trained personnel. Consequently, we recommend that Title IV training funds be restored to the fiscal 1981 level of $14 million.

DEMONSTRATIONS

We also urge that Title IV demonstrations be continued at the fiscal 1981 appropriation of $15 million.

Title IV demonstrations can be an effective management tool - especially in an era when funding for services programs may be stabilized or perhaps reduced. Demonstration programs can be effective models for stretching limited federal dollars to provide more social services to more older Americans more effectively.

Local area agencies on aging can, for example, use national demonstrations as models to improve service delivery for older persons in their communities.

In the past, the AOA demonstration program has yielded important benefits for our Nation, despite a relatively small budget. The nutrition program for the elderly is one of many outstanding examples to evolve from AOA demonstration programs.

The value of demonstrations becomes potentially great now because aging programs must do more with less or perhaps more with essentially the same amount of funding.

CONCLUSION

Our Nation is now preparing for the third White House Conference on Aging. We have made steady and substantial improvements for older persons since the first official White House Conference on Aging was held in 1961.

But, we must realize that older persons still face serious problems and formidable obstacles in our society. About 3.6 million persons 65 or older are poor. Almost one out of every four elderly Americans is either poor or near poor.

Many older persons are discovering that advancing age shuts them off from purposeful activity. Others are being placed in nursing homes - quite often prematurely and unnecessarily - simply because necessary in-home services are not available or are in short supply.

These problems are very real and demand serious attention. We may not be able to solve every one because of dwindling resources for services, training and demonstration programs. But, we must continue to address these issues, even though our progress is on a modest incremental basis.

Our Associations strongly believe that our proposals are fiscally and substantively sound. For these reasons, we reaffirm our support for (1) at least $277.1 million for the Senior Community Service Employment program and (2) continued funding for training and demonstration activities under the Older Americans Act at the fiscal 1981 level. We urge the Subcommittee to adopt these measures.

STATEMENT OF JEAN TUFTS, PRESIDENT, NATIONAL SCHOOL BOARDS ASSOCIATION

Senator PROXMIRE. Our next panel are representing views on the proposals for the elementary and secondary education; Jean Tufts, president of the National School Boards Association; Richard A. Kruse, assistant director for Federal Relations, National Association of Secondary School Principals; and Mary H. Futrell, secretary-treasurer, National Education Association. We will proceed on the same basis as before. I know the time is very constricted and I'm sure you can talk very persuasively at greater length, but we have a number of other panels waiting, so we would ask you to testify if you can in 2½ minutes, and then we will proceed with the next witnesses.

Our first witness is Jean Tufts, president of the National School Boards Association.

Ms. TUFTS. Thank you very much and we are very pleased to have this opportunity this morning.

I'm Jean Tufts, president of the National School Boards Association, and our association is a federation of 50 State associations and comprises 16,000 school districts with 95,000 school board members. Our members' primary purpose is to provide the highest quality educational services possible.

The Federal Government provides the public schools approximately 10 percent of their revenues. This figure includes the school lunch program. Thus, the Federal Government plays a significant role in helping us to achieve quality programs.

School board members reacted well to the President's commitment to confront our economic problems in mid-February. We know that the public schools have a vital role to play if any economic revitalization process hopes to succeed—that is, to succeed in the long run. We are disquieted, however, that the President proposed a deep cut in the Federal funding of elementary and secondary education programs as a part of the solution for the economic problems.

When elementary and secondary education programs are cut, an investment program is being cut. Education funding is among the more important ways this country invests. To cut education to the quick and then claim that the truly needy will not be harmed assumes that the Federal education funding is an overgrown welfare program, which we disagree with.

We are willing to do our share of the work to bring about economic solutions and to do our share of sacrifice, but our willingness should not be misread. It has been misread as meaning that education is an easy target for massive funding reductions. The National School Boards Association will not, in the name of cooperation, permit unchallenged an undermining of the concept of free public education.

On March 10, we were informed that the administration is proposing a 25-percent cut in fiscal year 1981. This cut will affect schools this fall. In addition, there will be no consolidation legislation this year to lessen the impact of these cuts. School districts all over the Nation have finished their budget cycle for the upcoming year 1981–82. They are depending upon the Federal Government to keep its advance funding commitment.

On behalf of the children we represent, we urge you not to rescind the fiscal year 1981 funds for elementary and secondary education upon which our local communities have been counting. The Federal investment in the public schools serves the public good of the Nation because the investment contributes to the capability of the people who participate in it. Participation, in the sense that we are using the concept, includes first the skills of governing and being governed; second——

Senator PROXMIRE. Could you wind up in 1 minute or so?

Ms. TUFTS. I would like to end up by saying that the National School Boards Association believes that Federal funding for ongoing programs should be maintained without rescission at the level now in fiscal year 1981 continuing resolutions on appropriations, Public Law 19–5536. In February 1982 these programs are recommended for a 7-percent increase as the Reagan administration recommends, but on the fiscal year 1981 base without the rescission. Thank you very much.

Senator PROXMIRE. Thank you very much, Mrs. Tufts.

STATEMENT OF MARY H. FUTRELL, SECRETARY-TREASURER, NATIONAL EDUCATION ASSOCIATION

Senator PROXMIRE. Mrs. Futrell, you're secretary-treasurer of the National Education Association?

Ms. TUFTS. Yes, I am.

Senator Proxmire. Go ahead.

Ms. FUTRELL. Good morning. I would like to comment on several items.

The administration's budget-slashing proposals come at a time when more—not less—Federal funding is badly needed for public education. They come at a time when a number of federally aided programs are beginning to show signs of success. They come at a time when many are questioning whether equal opportunity—and that includes equal educational opportunity—is going to be eclipsed by the bloodless pursuit of balancing numbers. They come at a time when local property tax bases are overloaded and State surpluses are gone.

NEA favors, and we have long favored, Federal funding of one-third of the budget of education in the form of general aid to the local districts with its spending left to the discretion of local agencies. This should be unfettered money for the local agencies to spend as they deem best.

NEA surveys show that 40 States have local or State limitations which would interfere with their ability to take up the slack if the block grant money is cut and if the Federal appropriations are changed.

There are four points which I would like to address at this time.

No. 1, forward funding and proper planning. Under the proposed cuts for fiscal year 1981 scheduled by the administration, school districts would be thrown into confusion, if not chaos. Elementary and secondary education funding currently operates under a congressionally mandated system that is essential for proper planning and budgeting. Forward funding by Congress—earmarking money so that school systems know what will be available next fall when the next school year gets underway—is the only sane and orderly way to proceed.

Under the administration's proposals, with rescissions for 1981 funding, fiscal integrity of local school districts would be destroyed. The cutback being proposed would mean that thousands of teachers would receive notices that their contracts are not being renewed. According to our figures, 58,000 teachers will be laid off for each billion dollars cut.

Second, impact aid. Long the target of would-be budget slashers, the administration proposal would cut the number of districts receiving funds from 3,900 to 330. We understand that the administration proposes the eventual elimination of impact aid in 5 years. We find it ironic, since this program is the closest to the block grant proposal which the administration espouses. I do not need to remind you of the responsibility owed by the Federal Government to those districts with too small a tax base and a large number of Federal installations who are laboring to meet their educational responsibilities.

Third, we join other vocational rehabilitation organizations and individuals in vigorously opposing the contemplated move of this program. The fundamental point being overlooked in such a reorganization is that vocational rehabilitation is not a welfare program, as some persons suppose mistakenly, but an educational program, and it is education to help people learn skills.

Fourth, the area of teacher centers. We have supported this program since its inception in 1976. Restricting the funding will reduce the number of centers. It has helped thousands of people.

In summary, no matter the rhetoric, the fictions, the pressures, the assertions, the claims and counterclaims, the fact is that the American public supports public education, and we know that the expectations are high and the funds are low. The public schools do not need, indeed we cannot afford, any of the cuts which are being proposed. Thank you.

Senator PROXMIRE. Thank you, Ms. Futrell.

STATEMENT OF RICHARD A. KRUSE, ASSISTANT DIRECTOR FOR FEDERAL RELATIONS, NATIONAL ASSOCIATION OF SECONDARY SCHOOL PRINCIPALS

Senator PROXMIRE. Our last witness on the panel is Richard Kruse, assistant director for Federal relations, National Association of Secondary School Principals.

Mr. KRUSE. Thank you, Mr. Chairman. It is indeed a privilege in coming before you today and thanks for the opportunity.

The NASSP represents 35,000 secondary school administrators across the land and let me say that we are a group of professionals who indeed understand what cutting budgets are all about. At the same time, we wholeheartedly support the budget approach that the Nation is pushing toward. At the same time we are indeed distressed that the reductions in spending for education are in fact disproportionately impacted on education.

Let me expand by saying we have grave concerns that the proposed budget cuts have been targeted to education more than any other Federal area. We find this to be inconsistent with the administration's supply side emphasis in the economy, since it is our opinion that indeed the greatest supply side element in this or any other economy is education—the Nation's schools which supply the work force with capable and productive citizens in this most dynamic, high technology economy. As evidenced by the disproportionate budget cuts, this most crucial element of our economy is taking a back seat as far as we're concerned.

Let me emphasize that in our view education is properly a local function, a State responsibility, and a Federal concern. Pulling back our resources while many of the interfering aspects of the Federal Government continue to plague our schools, is in fact backward in our minds. The cuts and the rescissions that the President has called for will have enormous rippling effects through our education programs and have significant detrimental effects on them. In many cases, school districts and administrators have already completed or nearly completed their budgets for the coming school year and that will be very difficult for them. In our minds, without a significant deregulation of these programs—a greater flexibility afforded schools which this committee cannot offer—these rescissions can only detract from the effectiveness of our Nation's schools in 1981-82.

We want to identify three programs we are particularly interested in to go ahead and work and help school administrators to go ahead and establish stronger leadership and greater emphasis in school improvement, and that is the title IV(c) funds that, as you know, are being cut significantly. We are distressed about that and call for the committee to assist us in holding back those rescissions.

The basic skills program, title II(f) of the ESEA we believe is a program that must continue to be funded; and thirdly, in the gifted and talented NASSP has long felt there is an imbalance of dollars not being spent for the gifted and talented programs at the same time the handicapped programs have been so highly spent for. We think that the gifted and talented programs should indeed be funded at least current levels.

Finally, as far as the categorical grants are concerned, the administration has called for consolidation in our block grant approach. We have long been supporters of simplifying the current morass of categorical programs. However, our support would evaporate immediately if this so-called block grant approach turned out to be a smokescreen for the elimination of Federal support for education. We need to deregulate and simplify——

Senator PROXMIRE. Could you finish in a sentence?

Mr. KRUSE. Yes, thank you. We need to deregulate and simplify the administration of programs before we cut their funding. I thank you, Mr. Chairman.

Senator PROXMIRE. Thank you, Mr. Kruse.

STATEMENT OF WAYNE PAXSON, ASSOCIATE SUPERINTENDENT OF SCHOOLS, BELLEVUE PUBLIC SCHOOLS, BELLEVUE, NEBR.

Senator PROXMIRE. I want to thank the three of you for excellent testimony. You make a very strong case for continuing funding at the present level and I very much appreciate it.

Our next panel consists of Wayne Paxson, associate superintendent of schools, Bellevue Public Schools, Bellevue, Nebr.; and James W. Maza of the National Association of Federally Impacted Schools.

Gentlemen, I think you're aware of the ground rules about time. Mr. Paxson, you go right ahead, sir.

Mr. PAXSON. Thank you, Mr. Chairman.

I'm Wayne Paxson, associate superintendent of schools at Bellevue, Nebr. Approximately two out of three pupils in our district are dependents of military personnel stationed at Offutt Air Force Base and Headquarters, Strategic Air Command.

Rather than speak to problems of impacted funding in our district, I would prefer to address those of highly impacted districts generally.

The budget recommends to fund only A pupils in a few impacted districts and then only at the 90-percent level, which will curtail education programs for severely impacted districts. The mathematics are simple. A district which depends on Public Law 874 for a major portion of its funding, as does our district, can only replace lost funds through an increase in local taxes. In our case, the increase in taxes required would be 50 percent. No district can stand such an increase. In any case, our State has a 7-percent lid on increases from State and local sources.

Clearly, a priority of funding must be established to insure that Public Law 874 goes to the most needy districts. I have five points which I want to emphasize in this regard.

One, the half-rate for a B pupil is as well justified as a full rate for an A pupil, particularly in a militarily impacted district. This basic concept is not generally recognized. A military impaction causes a greater impact than the civilian impaction, and in a district in which the installation is located impaction causes a greater effect than in other districts. The greater the percentage of relative impaction counting on an A pupil as one and a B pupil as one-half, the greater the need for full funding.

There exists in current law authorization for budget balancing in section 3(d)2(b) for needy districts which are 50-percent impacts. Use of this section for all Public Law 874 funding would insure that funds go only to needy districts. Its use would require that the Secretary of Education be directed to waive the portion of the law which states that a 50-percent impaction is required for eligibility under that section. Then a statement that tier II funding be provided for the most severely impacted districts meeting the remaining requirements of the section would meet most of the criticisms which have been leveled against Public Law 874 in the past 30 years.

Thank you for the opportunity to testify on this matter which is so very important to the severely impacted districts.

Senator PROXMIRE. Thank you, sir.

STATEMENT OF JAMES W. MAZA, COUNSEL, NATIONAL ASSOCIATION OF FEDERALLY IMPACTED SCHOOLS

Senator PROXMIRE. Our next witness is James Maza, counsel, National Association of Federally Impacted Schools.

Mr. MAZA. Good morning, Senator.

Since we're under significant time constraints due to your busy schedule I will be brief.

Our association represents school districts affected by the activities of the Federal Government and are accordingly eligible for impact aid.

The impact aid program provides noncategorical assistance to local school districts for the operating costs of educating children in areas where local costs and revenues are affected by Federal activity.

The purpose of the program is to minimize the fiscal inequities caused by the presence of the Federal Government in those areas.

Since I promised to be brief, I will submit to the committee four main points that summarize our position regarding the recommendation of the Reagan administration.

One, the administration's proposal would eliminate 3,700 to 4,000 school districts from program eligibility. This is a 92-percent reduction in school districts. The so-called super A districts would receive limited funding under the plan. Most school districts, however, would receive a 100-percent reduction or total elimination of funding during the next school year. Moreover, there is a request for 10-percent rescission for the current fiscal year.

Point two, three national studies inquiring into the merits of the impact aid program have been mandated by Congress and the executive branch since 1960. The Batelle and Stanford reports have both concluded that the impact aid program was an appropriate way for the Federal Government to help school districts affected by the Federal ownership and increased enrollments.

In 1978 this Congress mandated a presidentially appointed commission to study impact aid. This commission last year has given the program a ringing endorsement.

Point three, if impact aid is sharply reduced or eliminated, communities will raise property taxes or cut basic educational services. Moreover, some localities will attempt to charge tuitions to students or refuse to educate them free of charge. This year the Virginia General Assembly has passed a bill to allow its schools to charge tuition to the children of Federal employees. I believe that this is now pending on Governor Dalton's desk.

Point four, the Federal Government has an obligation to assist school districts in areas where enrollments are affected or tax bases are eliminated by the intervention of the Federal Government. The Federal Government owns now $100 billion in tax-exempt lands.

While our association understands the need to cut Federal spending, a reduction in the impact aid program does not reduce spending but merely shifts the burden from the Federal Government who originally caused this problem to the local taxpayers.

As the President's Commission on Impact Aid stated: "The basic premise of the program has validity today and will continue to have that validity until there is a major change in structure of financing public education."

In conclusion, as long as the Federal Government increases school enrollments and or eliminates part of the tax base, it has a responsibility to the affected communities. We accordingly urge this committee to recognize this Federal obligation which the Reagan proposals ignore, and provide an adequate education to the millions of children on Indian lands, in public housing, and on military bases around this Nation.

Senator **Proxmire**. Thank you, gentlemen. I appreciate both of your statements. I'm especially indebted to you, Mr. Paxson, for spelling out the priorities as you have so concisely at the beginning of your testimony. It gives us an interesting option.

Mr. PAXSON. Many of those, Senator, have been developed through the authorization and the appropriation process. They are not recommendations. They actually do exist in the language.

Senator PROXMIRE. Well, you say "should be continued." I take it that's a recommendation. If it's not, I'd like to know what it is. Thank you very much.

[The statements follow:]

STATEMENT OF JEAN TUFTS

- INTRODUCTION: STATEMENT OF GENERAL CONCERN

The federal government provides public schools approximately 10% of their revenues. Thus, the federal government plays a significant role in helping our public schools achieve quality programs so that the American people have an equal opportunity to succeed or fail in our economic system. Therefore, school board members reacted well to the President's commitment to deal with the five economic problems he identified on February 18th of this year.

He described "runaway inflation" as a major problem. We agree because school board members are responsible for the fiscal oversight and management of their school districts. The inflationary increases have been steadily eating into our capability to deliver services.

We wholeheartedly agree with the second problem: "excessive regulation." In many communities the federal regulations have eroded the local governance powers of school boards and have exasperated the school administrators to the degree that some have begun to see the federal government's money as an intrusion rather than a help.

In the area of tax burdens, we also commiserate. School board members know how difficult it is to raise the local and state funds that are required to operate the schools competently . We know that it is difficult to convince the public that, without adequate revenues, they will lose services that will cost much more to provide privately than publicly. Educating 90% of our nation's elementary and secondary students is one such service area. We are also concerned about the increasing budget deficits and the growth of the federal budget. School board members recognize the danger of irresponsible fiscal decisions.

Nevertheless, we were deeply disquieted when it became apparent that the President first noted these problems and then proposed, as part of the solution, a deep cut in federal funding for elementary and secondary education programs. It seems to be a belief of this Administration that the only way to invest in the future is to spend through tax expenditures. NSBA differs with the

Administration's perspective at this point. To cut education to the quick, and then claim that the "truly needy" will not be harmed, assumes that federal education funding is an overgrown welfare program.

When elementary and secondary education programs are cut, an investment program is being cut. Education funding is one of the most important ways this country can invest. It invests in the capability of its citizens to produce, both economically and socially. The National School Boards Association is deeply troubled that the Administration has apparently missed this connection between the schoolhouse and the corporate office.

The Administration's proposed reductions in every one of the major federal education programs ignores the function of schools in our economic infrastructure. The recent examinations of Japanese economic productivity is tied, by most observers, to that country's educated work force. For example, Nation's Business this month quoted William S. Anderson, President of NCR Corporation, saying that "it is no exaggeration to say that Japan is today the most literate, best-educated nation in the world. ... They transplant more easily into higher-technology jobs"[1].

The National School Boards Association (NSBA) does agree that changes -- in some cases major changes -- in the manner in which things have been done in the name of the public good must be altered. We are willing to do our share of the work and to do our share of sacrifice. But our willingness has been misread by some as meaning that education is an easy target for funding reductions that are far out of proportion for any viable arguments that all will participate equally in a national attempt to stabilize our economy. The National School Boards Association will not, in the name of cooperation, permit an attempt to undermine the concept of a free public education actualized by the nation's public schools to remain unchallenged.

- FEDERAL FUNDING FOR PUBLIC EDUCATION

Since February 18, the President has changed his education funding levels three times. In his February 18 document titled A Program for Economic

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[1] William S. Anderson, "What We Are Learning From Japan", Nation's Business, March 1981, pp. 39-41.

Recovery, he projected that elementary and secondary education in FY 1982 would receive 80% of the levels in the 1981 Continuing Resolution on Appropriations (P.L. 96-536). Within the next two weeks, we learned by newspaper that the Office of Management and Budget had made an estimating error and that $7 to $10 billion more in cuts could be expected. Soon afterward, we were informed by the press that elementary and secondary education would receive an additional 5% reduction and could anticipate a 25% cut from FY 1981 to FY 1982. In all cases, school districts were promised a consolidation package of major programs so that some of the troublesome, unnecessary and costly regulations could be lifted from the shoulders of school districts. Then, last week on March 10th, we were informed that the Administration is proposing a 25% cut in FY 1981 -- this fall. In addition, there would be no consolidation legislation to lessen any of the impact. From this base of 75% of the FY 1981 level, education is given a 7% increase for FY 1982.

As you are aware, the federal education programs are advance-funded. Programs receive their budget authority in one year and begin to receive the funds nine months later on July 1. This nine-month period gives the schools the opportunity to plan for the best use of the money. This year, this responsible management strategy has been turned against the public schools. Since the schools have not had the opportunity to spend their funds, these funds have been attacked as a cache to be robbed.

School districts over the nation have finished their budget cycle for the school year (1981-1982) which begins this fall. They are depending upon the federal government to keep its commitment. On behalf of local school board members and on behalf of the children they represent, we urge you not to rescind the FY 1981 funds for elementary and secondary education upon which these local communities have been counting. Using the FY 1981 Continuing Resolution on Appropriation figures as a base, we urge you to consider a 7% increase in FY 1982 over FY 1981 as the Administration has suggested (See Chart I).

CHART I

The National School Boards Association FY 1981 & 1982 Funding Recommendations

	1981 Continuing Resolution (P.L. 96-536)	NSBA Suggested 1982 Budget
Grants for disadvantaged:		
Grants to local educational agencies	$ 2,824,880	$ 3,022,622
Concentration grants	142,142	152,092
Emergency school aid:		
Grants to school districts	107,800	115,346
Special programs and projects	75,083	80,333
Magnet schools	30,000	32,100
Education for the handicapped:		
State grant program*	922,000*	1,089,660*
Preschool incentive grants	25,000	26,750
Vocational Education	779,241	833,787
Impact Aid	790,000	845,300
School Lunch	3,464,000	4,464,000

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*This program is held at an average of 12% of the extra costs required to educate a handicapped student.

- THE RELATIONSHIPS BETWEEN FEDERAL FUNDING AND LOCAL CONTROL

An argument being utilized as a justification for the severe reductions in education funding by this Administration is that schools are the major responsibility of local and state governments. NSBA is committed to keeping the governance of the public schools in the hands of the representatives of local communities. However, this commitment is not based on a narrow provincialism that divorces the local governance responsibilities of school boards from important national interests. There is a national interest in education that transcends but does not violate the fact that the state governments have the legal responsibility for educating our school children. There is tacit acceptance of this national interest even by the states when they pay approximately 50% of the staff in state departments of education with federal dollars.

School board members object when the federal government and the states over-regulate federal programs to the extent that they have almost no control over programs operating in the school districts for which they are held responsible. However, there are things best instigated at the federal level in partnership with local school districts. For example, the Education for All Handicapped Children Act (P.L. 94-142) improves the opportunity for handicapped children to receive an equal education.

This program is an excellent example of the investment at the local level the federal government is making in the nation's economic future. This program serves a clear national interest that is of a high priority. The same statement can be made about Title I of the Elementary and Secondary Education Act where educationally disadvantaged children in elementary school are given an opportunity to make faster progress in school; it can be made about vocational education where work skills are provided to students; it can be made for Impact Aid where school districts are reimbursed for the loss of revenue as a result of federal activities in their communities and other programs.

The best method for the federal government to make an investment in the educational process is by creating a partnership with local school boards. The federal investment in the public schools serves the general public good of the nation when it enhances the capability of people to participate in it. Participation in the sense that NSBA is using the concept includes the skills of governing and being governed, meaningful and useful employment, and service in the defense of the country. Education is an investment to assure the level of participation that is essential to a democratic society in each of these areas. responsiblity for funding elementary and secondary education in partnership with local school boards.

- ADDRESSING A PERCEPTION THAT ADVOCACY FOR PUBLIC ELEMENTARY AND SECONDARY EDUCATION STEMS FROM A SELFISH "SPECIAL INTEREST"

It is with grave concern that the National School Boards Association notes that among the variety of justifications used to defend the severe funding reductions is the dismissal of education advocates as "special interest" groups. Our objection to the FY 1981 cuts are dismissed in some quarters as the predictable shrieking of a "special" interest group whose advocacy of particular spending represents an unhealthy drain on resources needed to support the general public good. NSBA's interest in federal funding for public elementary and secondary schools springs from a commitment to public service directly benefiting children of school age in every local community. Our interest is special but not in a narrow selfish sense. Education is not a special interest where funding benefits only a select group. The education process that is generated and enhanced through federal dollars serves a broad national economic interest.

Neither are school board members representative of one type of education professional or one type of community. They do have one thing in common: a belief in the local public schools' capacity to educate. In 16,000 districts where board members serve to improve and enhance the educational system in their communities, most receive little or no reimbursement. With the threat of decreasing funding levels, their task is much more difficult. If the funding reductions proposed by this Administration are supported by this Congress, most communities will not be able to raise the funds to operate programs in the schools.

- Conclusion

The magnitude of cuts that will affect local communities from other proposed federal reductions beyond this subcommittee's jurisdiction, such as school lunch, highway and sewer construction, will make it necessary for communities to absorb these costs. It is going to be extremely difficult to raise the funds to operate the schools in the future. School board members are going to face excruciating decisions. Our early evidence indicates the nature some of the decisions that will be made. Teachers will be laid off, thus pushing up community unemployment rates. Inadequate salaries will be further eroded, thus limiting our capability to attract the most talented individuals for teaching jobs. Special programs will be limited with the result that some children who were formerly given that extra help to succeed will now fail. Court cases will multiply as services for those who should have special programs are cut. Any "savings" achieved from a sweeping 25% plus reduction in our education investments will be short-term at best. Our interest in protecting the federal funding that addresses the two major federal goals of equal opportunity and quality are not selfish from either the perspective of those who serve as school board members or from that of the school children who are the ultimate recipients of school board service.

STATEMENT OF MARY HATWOOD FUTRELL

I am Mary Hatwood Futrell, Secretary-Treasurer of the National Education Association, the largest organization of teachers and education staff in the nation. Our membership serves children in virtually all of the nation's 16,000 school districts.

Our gratitude in being invited to testify before your Subcommittee is unavoidably tinged with very deep concern and no small amount of alarm at what we and other educators--as well as concerned citizens--perceive to be a serious undermining of the nation's public school system, beginning with a starvation strategy.

The Administration's budget-slashing proposals come at a time when more--not less--federal funding is badly needed. They come at a time when a number of federally aided programs are beginning to show signs of success. They come at a time when many are questioning whether equal opportunity--and that includes equal educational opportunity--is going to be eclipsed by the bloodless pursuit of balancing numbers. They come at a time when local property tax bases are overloaded and state surpluses are gone.

Gentlemen, before discussing the specific issues for your consideration, I would like to make one observation which, I believe, can be overlooked easily in the entire budget-making process.

I believe that all of us, friend and otherwise, succumb too frequently to seeing the budget as a public nightmare described only with dollar signs and phrases such as "shortfall," "forward funding," "budget authority," "outlay," and all the other arcane terms.

We say that these are not just numbers we are talking about. We are talking about children. We are speaking about youngsters whose dream of equal treatment hangs in the balance. We are talking about a generation of Americans on whose future tomorrow's leadership will depend. We are speaking about young people whose futures are already troubled by health problems, inadequate housing, and questionable medical care. To add educational hurdles to those they already face is not something that you gentlemen would want to be credited with, I am sure.

Now, as to the specifics:

We favor--we have long been in favor of--federal funding of one-third of the budget for education in the form of general aid to local districts with its spending left to the local communities' education authorities. We believe, and we repeat, that this should be unfettered money, no-strings attached money, for the local education agencies to spend as they deem best in line with all of the Constitutional guarantees and responsibilities that more than 200 years of history have endowed us with.

Until there is sufficient assured funding for education, we need the existing categorical programs to meet the specific needs for which they have been designed to provide educational opportunity to youth who had special needs which local communities were unable or unwilling to meet. Categorical aid is the result of the long history of years of legislative process to ensure that all American children could be part of the American dream. The categorical aid programs are woefully underfunded--the Reagan Administration cuts would affect the 10 million children covered by the programs through more crowded classrooms or lessened programs.

We stand for general educational funding in addition to the categorical funding, not for supplanting, consolidating, and cutting other educational funds. The block grant approach proposed by the Administration would cut the heart out of the badly needed funding in the various categorical areas. If there are to be changes in the appropriations procedure, let them be mandated by Congress after due consideration for the issue involved, and--most important--the effect upon the schoolchildren of this country. Let the system work! It must not be short-circuited.

The process is particularly important to assure Congress and the people that adequate funds exist at the state or local level to assure educational opportunity for our neediest students. NEA surveys show that 40 states have local or state limitations which would interfere with their ability to take up the slack. In states hit by tax limitation amendments or high unemployment state education aid is currently being cut.

There are four points we would emphasize to the Subcommittee.

1. Forward Funding and Proper Planning. Under the proposed cuts for FY 1981 scheduled by the Administration, school districts would be thrown into confusion, if not chaos. Elementary and secondary education funding currently operates under a Congressionally mandated system that is essential for proper planning and budgeting. Forward funding by Congress--earmarking

money so that school systems know what will be available next Fall when the new school year gets under way--is the only sane and orderly way to proceed.

Planning for the teaching force, the numbers to be hired, the time and resources to be devoted to various curricula, the hundred-and-one details that must be attended to before even the first school bell rings, must be done between now and the end of April.

Under the Administration's proposals, with rescissions for '81 funding fiscal integrity of local school districts would be destroyed. The cutback being proposed means, in stark terms, that thousands upon thousands of teachers will receive notices that their contracts are not renewed. NEA Research shows that 58,000 teachers will be laid off for each billion dollars cut. School districts cannot be sure what money, under what formulas and conditions will be available! Such layoffs will not help the economy and they will not reduce the number of children to be educated.

2. Impact Aid. Long the whipping boy of would-be budget slashers, the Administration proposal would cut the number of districts receiving funds from 3,900 to 330. The argument is made that many of the districts that are refused impact aid money can benefit in other ways because federal employees living in those areas contribute to the local economy, increasing sales taxes and revenues for merchants.

Even if this were true--and it is by no means a certainty--it is far from clear that the proper portions from this alleged economic activity would go to finance education.

We understand that the Administration proposes the eventual elimination of impact aid in five years. This is indeed ironic. Impact aid is the closest program we have to the block grant approach which the Administration espouses. I need not remind you of the responsibility owed by the federal government to those districts with too small a tax base and a large number of federal installations who are laboring to meet their educational responsibilities. The Administration proposal to reduce impact aid from $724 million in 1981 to $401 million in 1982 is radically wrong and carries within it the further denial of equal educational opportunity to thousands of schoolchildren.

3. Vocational Rehabilitation Funds. As we understand it, the Administration proposes to remove this program from the Department of Education to the Department of Health and Human Services.

We must vigorously protest this contemplated move, joining other vocational rehabilitation organizations and individuals in this view. The fundamental point being overlooked in such a "reorganization" is that vocational rehabilitation is not a welfare program, as some persons suppose mistakenly, but an educational program. Its stress is on education and training, not on how to "make do" on a welfare check. It is education devoted to getting people off of welfare. It is education to help people learn skills. It is education for background in work and work-related activities, so that people are not dependent on welfare.

Most states recognize this principle and include their vocational education and rehabilitation efforts in their state education departments. We are confident that if Congress were to ask the state directors of vocational rehabilitation education about this, it would find that they prefer that this program--along with the programs of PL 94-142, Education for the Handicapped, for example--be administered with the aid of the Department of Education.

Finally, we should not be unmindful of the costs involved in any new "reorganization" of vocational rehabilitation education. The budget process is not the appropriate vehicle to reorganize services without an adequate hearings process.

4. Teacher Centers. Since 1976, when Congress and President Ford established the federal teacher center program, it has shown itself clearly to be one of the most unregulated, cost-efficient, and highly successful education programs.

Operating under restricted funding, the 99 teacher centers so far established are servicing 60 percent of the teachers in the teaching center areas with individualized one-to-one assistance in handling teacher problems, sharpening classroom skills, and meeting the many challenges of day-to-day classroom operation in a society affected by rapid and unrelenting changes.

The teacher center program currently consumes only 13/100th of one percent of the total Department of Education budget. The federal role has provided leadership without overriding federal regulatory influence.

If the Administration proposal to move the teacher center grant program into a state block grant is carried out, a major development may be expected: another layer of bureaucracy for a program which operates at the local level.

Gentlemen, I would like to thank you for your time, your patience, and your interest. I would like to leave you with this.

No matter the rhetoric, the fictions, the pressures, the assertions, the claims and counterclaims--the fact is that the American public supports public education. They also know that public school funds are low and expectations high. The public schools do not need, indeed cannot afford, reductions, or loss of funds, or elimination of programs that aid the poor, the handicapped, the bilingual, the gifted, and all the others we serve.

We earnestly ask that you consider these arguments in your deliberations aimed at doing what is best for the nation's 41 million public elementary and high school children.

Thank you.

STATEMENT OF RICHARD A. KRUSE

Thank you for giving me the privilege of coming before you today. My name is Richard Kruse. I am the Assistant Director for Federal Relations with the National Association of Secondary School Principals. The NASSP is made up of 35,000 secondary school administrators for both public and private institutions across the land, and are, in turn, responsible for the education of some 17 million youth.

I come before you today to share some of our concerns about the funding of education programs for this coming school year, and to express how principals feel about the significant changes in federal funding that have been proposed.

Let me first emphasize that there is perhaps no group of professionals who understand better what it is like to work within a stringent budget, and we extend our feelings of camaraderie to you and your colleagues in this regard. Furthermore, the administration's quest to balance the federal budget is supported wholeheartedly by our membership, and we will do our part to see that end accomplished. However, we are distressed that the reductions in spending have disproportionately been placed upon the backs of educators and the vital services they provide to every community in the nation.

Let me expand by saying we have some grave concerns that the proposed budget cuts have been targeted to education more than any other federal area. We find this to be inconsistent with the administration's supply-side emphasis in the economy, since it is our opinion that indeed the greatest supply-side element in this or any other economy is education—the nation's schools which supply the work force with capable and productive citizens in this most dynamic, high technology economy. As evidenced by the disproportionate budget cuts this most crucial element of our economy is taking a back seat as a federal interest.

Now let me emphasize further that in our view education is properly a local function, a state responsibility, and a federal concern. This concern has manifested itself in a number of ways over the past 25 years. In a lot of ways, interfering, in others misguided, but now, instead of reducing the interference, we see the resources diminishing very quickly. We call upon you, Mr. Chairman, and your distinguished committee, to emphasize the priority that our schools should have in this federal arena. Pulling back our resources while many of the interfering aspects of the federal government continue to plague our schools, is backwards.

More specifically, let me address the administration's proposed recissions. The ripple effect of these cuts in education programs scheduled to begin in September is significant. In many cases, school districts and administrators have already completed or nearly completed their budgets for the coming school year. These recissions will significantly interfere with education plans affecting literally millions of children and youth—not because they are recipients being denied special services—but because the existing mandates for handicapped and compensatory education will only require further resources to be drawn from hard-pressed programs. Without a significant deregulation of these programs—a greater flexibility afforded schools which this committee cannot offer—these recissions can only detract from the effectiveness of our nation's schools in 1981-82.

We call upon your committee, Mr. Chairman, to help moderate the recissions proposed by the administration, and to assist us in getting the message to the administration and your Congressional colleagues of the continued need to provide incentives for educational "capital development" in the same light as the administration seeks to stimulate business "capital development."

In our opinion, the appropriate role of the federal government is to provide incentives for the continued upgrading of the human and fiscal resources on which quality education depend, i.e., a stronger leadership in our schools, greater emphasis on school improvement, exemplary programs, and model school experiences. These educational "capital development" monies in Title IV C of the ESEA are targeted for a debilitating recission for 1981, and perhaps further watering down in the 1982 budget. We believe this program is vital to the continued strength of our schools and the priority we set for educational improvement today will be cost beneficial in the near future.

We also are distressed at the diminishing priority of the basic skills program, Title II of ESEA. Funding for stronger basic skills programs at the elementary and secondary levels must be a priority, and we urge the committee to review and turn back the administration's ill-advised 22% recission. We strongly believe that an appropriate federal role in education is to encourage schools to develop better methods of improving basic skills.

The third area in which we urge committee consideration is that of the gifted and talented. We at NASSP have long felt that a gross imbalance existed in federal assistance to schools when more than $5 billion is directed to disadvantaged and handicapped students, while a miniscule $6.3 million was expended for programs to enhance the opportunities of those students upon whom much of our future national success may depend. The residual benefits of upgraded programs for elite students will, we believe, also filter into the general academic program, and will, indeed, benefit all students. To see the administration call for even further de-emphasis of gifted and talented programs by a reduction of $1.6 million seems exceedingly short-sighted.

Mr. Chairman, you should be interested to know that NASSP has long been a supporter of simplifying the current morass of categorical educational programs. We have, for example, supported Senator Domenici's consolidation approach which has been put aside twice in the last several years. However, our support would evaporate immediately if this so-called block grant approach turned out to be a smoke screen for the elimination of federal support for education. We believe there is an appropriate role for the federal government in education. Our principals have been plagued with the responsibility for homogenizing the many federal grants which their schools are entitled to. To relieve our administrators of this monumental task, we have made our number one priority this year the simplification of these often duplicated and sometimes conflicting requirements that go along with many education programs. The maze of reporting requirements, needless to say, has deluged the principal to such a degree that his most important task—that of curriculum leadership—has been impeded. We will continue to work for a consolidation of programs bill which will reduce the complexity and provide the flexibility that school administrators need to serve the noble goals of educational opportunity and quality for all students. But we need to deregulate and simplify the administration of the programs before their funding is cut.

Thank you for the opportunity to share our membership's concerns with this most distirguished committee.

Thank you.

STATEMENT OF JAMES W. MAZA

The National Association of Federally Impacted Schools appreciates the opportunity to present its views on the FY1982 budget as it affects the Federal impact aid program. The Association represents approximately 1,000 of the 4,000 school districts currently eligible to receive impact aid.

If the budget proposal sent to Congress becomes law, many public schools which rely on impact aid as a major part of their general support would face serious fiscal dislocation. The Reagan plan for impact aid would completely eliminate funding to over 3,500 school districts and would substantially reduce funding to all remaining school systems. Seventeen states would lose all money currently derived from impact aid. The loss of impact aid funding would force school districts to raise local property taxes and/or cut or eliminate educational programs. In some school districts, the proposal would cause school closings or loss of accreditation.

The federal impact aid program provides assistance to local educational agencies for the operating costs of educating children in areas where local costs and revenues are affected by federal activity. The purpose of the program is to minimize the fiscal inequities caused by both the presence of federal tax exempt property and the increased burden of providing education to large numbers of children whose parents reside on federal property and/or work on federal installations or in the Armed Services.

The current law recognizes that local school districts are dependent on tax revenue from (1) residential property of individuals and (2) commercial and industrial property. Accordingly, the impact aid law established three main categories of pupils:

(1) pupils whose parents both live and work on federal tax exempt property and pupils living on Indian lands - "A" pupils;

(2) pupils whose parents work on property that is tax exempt - "B" pupils;

(3) pupils who live in Federal tax exempt public housing - low rent "B" pupils.

The program is funded through a weighted entitlement system which authorizes payments for the various subcategories of pupils. The categories reflect the "impact" that the type pupil has on the community. Consequently, the military "A" and Indian pupils are the pupils with the greatest funding allocations. "B" payments are funded at a lesser amount in recognition that the school district receives some tax benefit from their parents.

The federal government owns $101 billion dollars in tax exempt property. The fact that school districts are forced to rely on property taxation as the primary source of revenue creates an inequity in districts with significant federal ownership. Additionally, the presence of numbers of federally connected children adds considerable costs to local budgets.

Over the past decade and even before, the overriding problem concerning Impact Aid has not been whether A payments should be 90% or 100% of the local contribution rate, or in which tier section 2 entitlements should be paid. The basic problem concerning Impact Aid has been the persistent refusal of the Executive branch to acknowledge the federal obligation to communities affected by federal activity. Why this is true is open to speculation. School officials have tried time and time again to open a dialogue with the various administration appointees. These attempts have been unsuccessful. It seems that as certainly as there will be a federal budget proposed each year, included in that budget will come a call for a reduction in Impact Aid funding. To support these proposals, little if any data, reasoning or evidence is offered. As Secretary Califano once noted, it was "the annual rite of spring."

We, as school officials, see these trips to Washington year after year as an exhausting exercise in debt collection. I want to emphasize this analogy. To the local community, the federal government owes a debt for educational services rendered just like every other householder or employer in the community. The Administration officials say this is a state responsibility, and the state officials say that the problem was caused by the Federal government and that the obligation--if you will, the debt-- is owed by Uncle Sam. The locals propose that tuition be charged to federally connected pupils or that they be barred from school because they are a drain on the local taxpayer. It is the same story told each year by the Federal government. The first answer is, "We don't owe the money," the second story is, "We will pay five, ten or twenty cents on the dollar." This is not fair. This is not just. The survival of a quality education to the millions of children educated in the thousands of schools which are affected by the policy of the Federal government depends on every part of the community, including the federal imployers or landowners, paying its share of the educational services provided.

Over the last two decades Congress and the Executive Branch have mandated three national studies inquiring into the equity and purpose of the impact aid program. All three studies have concluded that the impact aid program makes sense and is a fair way for the Federal government to assist local schools affected by Federal activity. In 1979 a Presidential Commission on the Review of the Federal Impact Aid Program was established by law. During the course of its deliberations the Commission issued an interim report. This report stated in part:

> "The Commission finds that . . . any reduction in the level of appropriations of Public Law 874 will cause serious disruptions in the operation of many schools and, in the case of the more heavily impacted districts, school closings [and] that the basic premises of the program have validity today and will continue to have that validity until there is a major change in structure of financing public education."

This year, as in past years, a proposal has been made in the President's budget to fund only some of the category "A" students (those who live on and whose parents work on federal property), and to not fund the category "B" students in school districts. Because the "A" child resides on non-taxpaying land and his parent works on non-taxpaying land, the school district receives no tax benefit from his presence in the school district. Indeed, it follows that his presence is a financial burden to the school district. Therefore, it is difficult to understand why a district should be forced to educate an "A" pupil without funding assistance from the Federal government. The case is more dramatically illustrated by the Indian "A" pupil. Accordingly, we urge the committee to adequately fund the "A" category of P.L. 874.

The Reagan proposal requests no money for "B" payments. This defies all of the findings of the three national studies on impact aid. School districts only receive a fraction of the money for a "B" pupil as compared to the "A" category pupil. The Stanford Report on Impact Aid stated as follows:

> "It may be noted that once the burden principle is accepted, there is no reason to exclude Section 3(b) pupils from eligibility; these are pupils who live with parents who either live or work on federal property, but not both. They are almost entirely the latter, i.e., pupils whose parents work on federal property. Their eligibility rests upon the fact that school districts are generally unable to maintain, with reasonable effort, levels of expenditure derived only from residential property taxes. The burden is created by the absense of taxes on places of work. The burden in each district depends upon the balance of residential and business property in the district, and may be negligible for a predominantly bedroom community. Nevertheless, there is no justification in principle for excluding the 3(b) pupil from payment." (emphasis added).

As long as school districts depend on property taxation as a major source of revenue and that property tax is levied on both residential and commercial properties, fairness dictates that the Federal government continue to funddistricts pursuant to a weighted formula which funds both "A" and "B" pupils in recognition of this dual (residential and commercial) tax base.

Local school districts have always valued the non-categorical nature of impact aid funds. This feature has allowed the school district to use this resource in a very cost-effective way, free of extensive Federal control and regulation. School districts have depended on this funding to implement basic educational programs. Any reduction in funding would undermine the basic educational program in many districts.

The impact aid program is a dependent program. School districts are only paid for children that they actually serve and educate. As the Federal government increases its Armed Services, public housing projects, or other Federal installations or Indian reservations, the impact aid program grows in direct proportion to the increase in Federal activity.

Our Association understands the need to reduce government spending, however a reduction in the impact aid program does not reduce government spending, but merely shifts the burden from the Federal government, who originally caused the problem, to the local taxpayer. If impact aid payments are eliminated, many communities will attempt to charge tuition for federally connected students or simply refuse to support their education. This type of reaction caused Congress during and after the Second World War to provide financial assistance in the form of impact aid. As the President's Commission on Impact Aid noted, "the basic premises of the program have validity today and will continue that validity until there is a major change in structure of financing public education." As long as the Federal government increases school district enrollment and/or eliminates part of the school district tax base, it has a responsibility and obligation to the affected communities. We urge this Committee to recognize this Federal obligation, which the Reagan proposal ignores, and provide an adequate education to the millions of children who reside on Indian lands, in public housing, on military bases or whose parents work on federal tax-exempt property.

STATEMENT OF WAYNE PAXSON

Mr. Chairman - I am Wayne Paxson, Associate Superintendent of the Bellevue Public Schools at Bellevue, Nebraska. My school district provides educational services to Offutt Air Force Base and Headquarters, Strategic Air Command. Approximately two-thirds of our enrollment is federally connected and approximately 40% of our budget normally comes from PL 874 funding.

Rather than speak to the needs of my district only, I want to address my remarks to the needs of the severely impacted districts which are primarily those serving Indian reservations and military reservations.

PL 874 is not a recent product of the Great Society. It is an in-lieu-of-tax which goes back to 1950. Prior to 1950, other laws had been enacted to deal with the problems of impaction. These laws were created to solve a problem which was created by the federal government and which still exists today, namely, to assist in the costs of education for dependents of those persons who are present in large numbers due to a federal activity. In my own district, federal impaction dates back to the late 1800's when dependents of soldiers stationed at Fort Crook attended the public schools.

For PL 874, the federal activities were originally those related to the military buildup following World War II. They now also include Indians, Cuban refugees, civil service employees, and low-rent housing residents. There have even been proposals made to include undocumented aliens under the program.

For the first twenty years of PL 874, the bill was fully funded. Since 1969, prorations of various amounts have occurred every year. It is extremely unlikely that the bill will ever again be fully funded. If the federal government is going to continue to welch on its obligations, it should at least attempt to pay its bills to those who cannot possibly operate without the funds.

Over the years, both the authorization and the appropriation processes have recognized two major methods of establishing priorities when appropriations are insufficient to fund all applicants, (1) based upon the category of pupil (that is the kind of impaction) and (2) the degree of impaction, most often identified as the per cent of enrollment made up by federally connected pupils, or in some instances, the per cent of expenditures made up by the PL 874 payments.

Examples of each kind follow:

Category of Pupil -

(1) A military pupil causes a greater impact than a civilian pupil due to the Soldiers and Sailors Relief Act and on-base shopping privileges.

(2) An "A" pupil causes a greater impact than a "B" pupil. In fact, the impact of an "A" pupil is on the average, twice that of a "B" pupil. For this reason, the half-rate for a "B" pupil is as well justified as the full rate for an "A" pupil. Total elimination of "B" payments is not an equitable way to cut appropriations.

(3) The impact of a federal installation is greater upon the district in which the installation is located than upon neighboring districts due to the fact that the tax base of the district is reduced in an amount equal to the value of the property removed from the tax rolls.

Degree of Impaction -

(1) One category of degree of impaction is that of 20% with "A" pupils. Tier II funding is justified for all categories of pupils in such districts.

(2) Section 3(d)2(B) allows for a budget balancing provision for needy districts which are at least 50% impacted with any combination of "A" and/or "B" pupils. However, unless the Congress specifically earmarks funds for this section, it will be prorated and the most deserving of the recipients of PL 874 will be penalized the greatest amount.

(3) Perhaps a third category of degree of impaction should be recognized by the Congress, one which is recommended by the Presidential Commission for the Review of Impact Aid. This category is one in which "relative" impaction is determined by counting an "A" pupil as one pupil and a "B" pupil as one-half a pupil. As an example, a district with 1,000 pupils, of which 100 were "A" pupils and 300

were "B" pupils would be considered to have a "relative" impact of 25% (100 "A" pupils plus one-half of "B" pupils equals 250 pupils, or 25% of the total enrollment).

(4) The percent of expenditures made up by PL 874 entitlements is an accurate measure of reliance upon PL 874 funding. An example follows: In a district in which only one percent of funds come from PL 874, a 50% proration causes one-half of one percent of an annual budget to be made up from other sources. For a district in which 40% of funds come from PL 874, an across-the-board cut of 50% would cause 20% of the annual budget to come from other sources. The more likely result is a 20% cut in expenditures since local taxes most often could not make up the difference. The impact upon the latter district of an across-the board 50% cut is twenty times greater than upon the first district.

In summary, priorities of funding which now exist must be continued and new ones must be developed if school closings and disruptions of education for many of the nation's youth are to be avoided. These priorities must be for:

(1) Indians and military (both "A's" and "B's")

(2) Super A districts and 50% impacted districts (both "A's" and "B's")

(3) In-district impaction should receive a higher priority than other types.

(4) A new category of relative impact should be created (both "A's" and one-half of "B's").

(5) In the event Tier II funding cannot be provided to accomplish all of the above priorities, the Secretary of Education should be directed to waive the 50% requirement in Section 3(d)2(B) for the highly impacted districts and this section should have first priority on the available funds.

STATEMENT OF CAROL GROSSMAN, PRESIDENT, WOMEN'S EQUITY ACTION LEAGUE, NATIONAL COALITION FOR WOMEN AND GIRLS IN EDUCATION

Senator PROXMIRE. Our next panel is on equal educational opportunities, Carol Grossman, president, Women's Equity Action League, National Coalition for Women and Girls in Education; and Dr. Thomas Van Dam, superintendent, School District 151, Cook County.

Ms. Grossman.

Ms. GROSSMAN. Thank you.

Mr. Chairman and members of the subcommittee, I appear before you today as a representative of the organizations active in the National Coalition for Women and Girls in education, a federation of organizations working to strengthen Federal policies and practices which promote educational equity. We are testifying today in support of the appropriations for the Women's Educational Equity Act program, title IV of the Civil Rights Act, and the Office for Civil Rights.

The organizations which support this statement are listed on the more complete copy of the testimony.

Although we are aware that the United States must come to grips with a critical economic situation and that many spending cutbacks are necessary, we consider the current proposal to reduce funds for elementary and secondary education programs in the U.S. Education Department by 25 percent in fiscal year 1981 and to provide for minor increases in these allocations in upcoming years to be shortsighted and a false economy. Formal education plays an instrumental role in the preparation of our youth for productive adult lives. Even though public education is a primary responsibility of the States and local areas, the Federal Government has an obligation to insure that each child receives an equitable education.

The Women's Educational Equity Act program was enacted by Congress in 1974 to promote educational equity for males and females. Grants and contracts are awarded each year for the development, demonstration and dissemination of model educational equity products and programs which have the potential for national, regional or statewide impact.

The original purpose of title IV of the Civil Rights Act of 1964 was to assist racially segregated school districts with specialized training and advice to accomplish desegregation. During the 1970's the program was broadened to offer specialized assistance in ending sex and national origin discrimination as well.

Title IV funds are carefully targeted and provide the most assistance with a small investment of Federal dollars. The program offers educators and administrators the expert help they need to make necessary changes in discriminatory educational policies and practices but does not actually pay for school desegregation.

OCR has a very important task in administering many laws and regulations covering sex discrimination and other areas if we are to maintain the integrity of its funding which will assist it in meeting its court ordered obligations.

We recognize that you have before you a budget that rescinds a great deal of funding and we would urge you to weigh carefully the many benefits that WEEA, title IV and the enforcement efforts of OCR against their insignificant cost relative to the entire Federal budget. We are certain that, having done so, you will recognize that the achievement of educational equity is worth the expense and should not be jeopardized in the interest of saving a few dollars now.

Senator PROXMIRE. Thank you very much, Mrs. Grossman.

STATEMENT OF THOMAS E. VAN DAM, SUPERINTENDENT, SCHOOL DISTRICT 151, COOK COUNTY, SOUTH HOLLAND, ILL.

Senator PROXMIRE. Dr. Van Dam.

Mr. VAN DAM. I am Dr. Thomas Van Dam, superintendent of School District 151, South Holland, Ill. I believe we are the first school district under the first desegration court order north of the Mason-Dixon Line in 1968 and I have been the superintendent there from the onset of the desegregation court order.

Basically, from my experience from 13 years as a superintendent, the school district has received little or no help from the State with the desegregation problems either financially or through other help. Basically, the district has been able to carry out its school program principally through grants won by the school staff, heavy in financial grants to support the school district.

Based on my experience with the State, I think I personally have great fears that if block grants do shift to the State I'm concerned that in the process the school district will not only lose programs, the 20-percent reduction in funds through the cuts, but as it passes and filters through the State that we will lose another 10 or 20 percent of the amount of moneys we now receive through Federal grants.

I would hope that Congress would consider maintaining its present funding process. My district, perhaps more than any other in the State of Illinois, has had to deal with the Federal Government in terms of regulations, audits, on-site visits, OCR and all the rest. I have never experienced any specific problems with them and have been able to carry out our duties with the school district without any problems.

The quality of the school district is good and orderly and I hope, Senator, that my experience as a superintendent for a long-term desegregated school district will influence your preferences in this matter.

Senator PROXMIRE. Thank you very much.

I appreciate the testimony, Miss Grossman and Dr. Van Dam, very much.

STATEMENT OF EILEEN D. COOKE, ASSOCIATE EXECUTIVE DIRECTOR, AMERICAN LIBRARY ASSOCIATION

Senator PROXMIRE. Our next witnesses are libraries and learning resources. We have one witness, Miss Eileen Cooke, representing the American Library Association.

Ms. COOKE. Thank you, Senator Proxmire.

I appreciate the opportunity to appear before the committee and to recognize that I'm all alone, but I have a large burden. We have at least eight different library programs that are covered by appropriations that come from this committee. You have my printed statement with a summary on top and you will note that at the time we submitted this we did not have access to President Reagan's budget proposals and I guess you might say this reflects the position many libraries are in now as their budget are being cut back. Researchers go to the shelves and find the materials aren't there. So I can certainly sympathize with them.

However, in between the time that we submitted this and the President's proposals did come out, I got access and I have three sheets with some State breakdowns that I would be glad to submit for the record that shows our interpretation of what this will mean.

Senator PROXMIRE. We would be happy to have that.

Ms. COOKE. Just a general comment on the adverse impacts the budget proposals would have, I'd make the point that libraries in general have the same types of inflationary cost increases that business has and that every household has. This is heat, light, maintenance costs, and then on top of that we must add those essentials that make us libraries and viable libraries. Look at the price of books, films, tapes, periodicals, both domestic and foreign. According to the Department of Education the average book price since 1967 has increased 169 percent to $23.80 in 1980. Magazines average price have gone up 299 percent in that same period. These impact very adversely so that even if the same amounts were recommended it would still have an extremely adverse impact.

The University of Wisconsin Library was telling me last week that their periodical budget represents a 26-percent increase in average cost.

So I would urge that this committee very carefully consider because we are cutting off the research arm of the Nation and it's going to be a crisis within a few years, particularly in the college and university community. Thank you very much for the opportunity to testify.

Senator PROXMIRE. Thank you, Miss Cooke, very much for a fine presentation. I appreciate especially the reference to Wisconsin.

STATEMENT OF MARGE DeBLAAY, CHAIRPERSON, NATIONAL AFFAIRS COMMITTEE, NATIONAL SOCIETY FOR AUTISTIC CHILDREN

Senator PROXMIRE. The last panel is the Education for the Handicapped; Marge DeBlaay, chairperson, National Society for Autistic Children; Martin A. Adler, director, and Robert Smithdas, Helen Keller National Center for Deaf-Blind Youths and Adults; and Vincent Gray, Governmental Affairs Committee, Association for Retarded Citizens.

Our first witness will be Marge DeBlaay.

Mrs. DeBLAAY. Having just arrived here and being new to this, I was told I had five minutes but I have been given the message that I have even less. Shall I cut back even more?

Senator PROXMIRE. Do what you can do with the 3 minutes that we have. We want to treat everybody alike rather than discriminate.

Mrs. DeBLAAY. OK. Let me just go ahead and talk to you a little bit. I'm Marjorie DeBlaay and I am the mother of a 9-year-old son who has autism. I am chairman of the National Affairs Committee of the National Society for Autistic Children and am here today to represent the organization, and this is my son, Michael, who's 9 years old and who has autism.

Very little is known about autism. We do know that it affects the way their senses take in information which causes many problems in both communication and in behavior. There is no cure known for autism and the Appropriations Committee in the past has supported us in trying to get research out of the NINCDS and we appreciate that.

In the meantime, the one thing that works best for autistic children is highly structured educational programing and that's why I brought Michael along today, because Michael is a real success story in the world of the educational program for the autistic.

Two years ago Michael didn't even know the alphabet. Now he's working on a second grade level of reading, a third grade level in mathematics. He is about only a year and a half behind an appropriate age group. Michael did not talk at all until he was 5 years old. He still has severe articulation problems but he can communicate with us finally rather than screaming most of the time, and this is thanks to that appropriate education and a fantastic teacher, and we in the Autistic Society are very concerned about the proposals of block grant education to the handicapped along with the many various proposals that it has been put into.

We finally got the Department of Education to recognize autism as something other than an emotional disorder this year. We don't think we are going to win a fight in every local school district in the country to get appropriate educational programing. Thank you.

Senator PROXMIRE. Thank you, Mrs. DeBlaay. Most moving.

STATEMENT OF MARTIN A. ADLER, DIRECTOR, AND ROBERT SMITHDAS, HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTHS AND ADULTS

Senator PROXMIRE. Director Adler and Robert Smithdas.

Mr. ADLER. Good morning. My name is Martin Adler, director of the Helen Keller National Center for Deaf-Blind Youths and Adults. I would like to introduce Dr. Robert Smithdas who is director of our community education program. Dr. Smithdas has been deaf and blind since the age of 4.

Mr. SMITHDAS. In 1969 Congress enacted legislation for the establishment of a national center to provide training and rehabilitation for deaf-blind citizens, a group of severely handicapped people who have often been neglected and denied service. Since 1969, Federal funding was gradually increased to enable a comprehensive center for the deaf and blind to be built in 1976. Today, the Helen Keller National Center for Deaf-Blind Youths and Adults provides rehabilitative and prevocational services to deaf and blind persons on a national basis, funds and training for professionals, and provides research into the problems of and the technical devices necessary for the deaf and blind throughout the United States.

The Helen Keller National Center has helped the handicapped persons who are unable to hear or see and who are often denied services within their own society.

The Federal funding was increased early in 1976 and more services are provided in the training of the deaf-blind and training of deaf and blind professionals.

President Reagan has been proposing block grant funding for health and service organizations that will be distributed throughout the States.

Block grant funding would not be in the best interest of deaf and blind citizens because their need for special rehabilitative services would be overwhelmed by larger groups of other handicapped who can make the greatest impact on State and Federal bureaus in terms of numbers, militant actions, or claims to have the highest success rate. Some States have not allocated scarce rehabilitation moneys to severely handicapped groups because of the so-called limited success rate.

We feel perhaps deaf-blind people would be pushed back and the quality of training would be reduced.

Senator PROXMIRE. Could you finish in about a sentence?

Mr. SMITHDAS. Finally, I question that your subcommittee will continue Federal funding of the National Center and that the deaf and blind will suffer.

President Reagan said only the truly needy would be saved. We feel President Reagan and his advisers were talking about the deaf-blind population.

Senator PROXMIRE. Thank you very much, Mr. Smithdas. I appreciate the fact that both you and Mrs. DeBlaay come in under these difficult circumstances. I think you have both done a superlative job and we are very appreciative.

STATEMENT OF VINCENT GRAY, GOVERNMENTAL AFFAIRS COMMITTEE, ASSOCIATION FOR RETARDED CITIZENS

Senator PROXMIRE. Mr. Gray, Association for Retarded Citizens.

Mr. GRAY. Thank you, Senator. Good morning. I'm pleased to represent our 300 local units and our almost 300,000 members to speak to these budget issues.

Mental retardation is a lifelong disabling condition with no known cures which requires, in many cases, a continuum of services throughout the life of the individual. Basic services such as special education, vocational rehabilitation, residential placements, and social and medical services are essential to prevent unwarranted and costly institutionalization and wasted lives.

The parents of the approximately 6 million mentally retarded citizens of our country are presently gravely concerned about President Reagan's economy recovery program, which, if implemented as proposed, will drastically affect the lives of mentally retarded citizens and their families.

There is hardly a service program funded by the Federal Government currently available to mentally retarded people wherein their continued eligibility and access to the program is at great risk or the program itself faces serious funding cutbacks. Time does not permit me to review all of our concerns today, so I will concentrate on those vital programs funded through the Department of Education.

Since 1975, mentally retarded children have benefited greatly from the enactment of the Education for All Handicapped Children Act. This act guarantees each and every school-aged handicapped child, regardless of the severity of the handicap, a free, appropriate education. The act assists State and local education agencies by partially financing the costs of the special education program. In 1981, through an appropriation of $922 million, the Federal share amounts to approximately $235 per child, which represents about 11 percent of the average cost of special education. The passage of the Education For All Handicapped Children Act was particularly crucial to the parents of severely and profoundly mentally retarded children, most of whom had had the doors of education firmly closed to them in many States prior to the enactment of the act. These unfortunate children are not profiting from their educational opportunities. Despite their handicaps, many are being trained to care for themselves and to contribute to society in some way in their adult years. To the parents of these children, programs such as special education are a great relief, not only in the training and skill development available to their children, but also in the hope for a real future for the children.

It is incredible to us that the President now proposes to repeal this vital act, thereby potentially, in fact most likely, destroying the basic right to education for all handicapped children. This would be accomplished by block granting the education for the handicapped State grant program and the preschool incentive program to local school systems and repealing the Education For All Handicapped Children Act. In addition to repealing the law and establishing the block grants, the President also proposes to make a 25-percent reduction in the Federal role in financing the education of handicapped children.

Although the members of our association clearly recognize the need to solve the economic ills of our Nation, we cannot understand how the administration expects to succeed by abolishing the right to education and reducing its commitment to educating handicapped children. Someone must realize that the withdrawal of educational opportunities for mentally retarded children will significantly enhance the likelihood of additional, much more costly, lifelong services for these people. The effects on future Federal budgets will surely be negative, to say nothing of the impact on the lives of the families of these children.

We were greatly heartened by the actions of the Senate Labor and Human Resources Committee last week when it reported its recommendations to the Budget Committee for fiscal year 1982 special education and vocational rehabilitation spending levels. That committee rejected the Reagan cutbacks, instead endorsing a 10-percent increase above the level recommended by the Congressional Budget Office. The Association for Retarded Citizens strongly supports this level of $1.14 billion for the education for the handicapped State grant program for the fiscal year 1982 budget. This increase will allow the Federal Government to continue to reimburse school systems at approximately the same percentages as in 1981 and allows for the anticipated increase in the number of handicapped children to be served in the next school year by at least 50,000 children. We urge this committee and the entire Congress to appropriate this $1.14 billion figure to at least retain this program at its present level and allow additional children who need those services to be served. Thank you, Senator.

Senator PROXMIRE. Thank you, Mr. Gray. I want to once again thank all of you for very, very moving testimony. I was deeply impressed and I'm sure the other members of the committee will be too.

[The statement follows:]

STATEMENT OF CAROL GROSSMAN

Mr. Chairman, and members of the Subcommittee, I appear before you today as a representative of organizations active in the National Coalition for Women and Girls in Education, a federation of organizations working to strengthen federal policies and practices which promote educational equity. We testify today in support of:

- an appropriation of $15 million for FY 1981 and $20 million for FY 1982 for the Women's Educational Equity Act Program;
- an appropriation of $45.7 million for FY 1981 and $54 million for FY 1982 for Title IV of the Civil Rights Act; and,
- an appropriation of $46,915,000 for FY 1981 and $50,971,000 for FY 1982 for the Office for Civil Rights/USED.

We would also like to briefly address the issue of education program consolidation as it affects educational equity. The following Coalition organizations support this statement:

American Association of University Women
American Educational Research Association Women's Group
American Personnel and Guidance Association
Association for Intercollegiate Athletics for Women
Council of Chief State School Officers' Resource Center on Sex Equity
Federal Education Project of the Lawyers' Committee for Civil Rights Under Law
National Commission on Working Women
National Council of Jewish Women
National Student Educational Fund
National Women's Political Caucus
National Women's Studies Association
Project on the Status and Education of Women, Association of American Colleges
United States Student Association
Women's Equity Action League
Women's Equity Action League Educational and Legal Defense Fund

Today's youth are tomorrow's future. They are the best and most promising natural resource that the United States possesses. The way that our systems and institutions nurture that resource in the coming decades will shape history long after each of us in this room is gone. Funds spent wisely in this decade for the education of our youth will be repaid with interest by a capable and productive work force in the future.

Although we are aware that the United States must come to grips with a critical economic situation and that many spending cutbacks are necessary, we consider the current proposal to reduce funds for elementary and secondary education programs in the U.S. Education Department by 25% in FY 1981 and to provide for minor increases in these allocations in upcoming years to be shortsighted and a false economy. Formal education plays an instrumental role in the preparation of our youth for productive adult lives. Even though public education is a primary responsibility of the States and local areas, the Federal government has an obligation to ensure that each child receives an equitible education. Federal dollars directed towards specific program initiatives that focus on the needs of certain populations -- women, racial and ethnic minorities and disabled individuals for example -- historically ill-served by State and local education programs are, in many cases, the only dollars that are spent to ameliorate the effects of discriminatory educational policies and practices experienced by these groups.

In addition, because federal funds provide remedies that have a positive impact on populations far greater than those for whom the programs were originally designed, they are a most effective use of limited resources.

Women's Educational Equity Act Program

The Women's Educational Equity Act (WEEA) Program was enacted by Congress in 1974 to promote educational equity for males and females. Grants and contracts are awarded each year for the development, demonstration and dissemination of model educational equity products and programs which have the potential for national, regional or statewide impact.

Projects can focus on all levels of education and all disciplines within education. Thus, WEEA has the capacity to look at the entire educational system and its processes and to address equity issues in many ways.

The Act also established a presidentially-appointed National Advisory Council on Women's Educational Programs which has broad powers to advise Federal officials concerning the improvement of educational equity for women and girls and to evaluate administration of the Act.

When WEEA was reauthorized in 1978, its mandate was expanded to include:

- support for a second type of activity -- projects designed to help local school districts achieve compliance with Title IX and provide educational equity for students of both sexes. Funding for this second program is to be triggered by an appropriation that exceeds $15 million; and,
- the identification of funding priorities so that resources from this small program can be targeted on critical sex equity issues and specific populations. Current priorities include: model projects to promote educational equity for racial and ethnic minority women; and, model projects to promote educational equity for disabled women. Fifty-five percent of the FY 1981 new award funds are earmarked for these priorities.

In 1979, five national demonstration site contracts were awarded to agencies who, with the cooperation of school personnel and community members in Tucson, AZ, Quincy, MA, Lincoln County, OR, Reidsville, NC and Broward County, FL, are implementing, evaluating and documenting the effectiveness of women's equity materials at the local level. Schools within the five systems are functioning as models of educational equity while demonstrating their programs to educational personnel and other interested visitors.

Local response to these contracts has been very positive. For example, the assistant superintendent of schools in Lincoln County says that:

> This program will provide an effective model for use within the region. The value of demonstration models cannot be overemphasized. They can provide an accessible, effective way to share the day-to-day realities of educational equity with a large number of educators.

And, from a Reidsville school administrator, we hear that:

> What's happening (as a result of the demonstration contract) is hastening things to come....things were already happening in society that would cause eventual change. The (WEEA) program is creating an awareness of changes and providing the impetus and resources to enable swifter change.

Requests for WEEA materials come from school administrators, hospital staff, business executives, adult education faculty, university deans, school and college counselors, librarians, job training and rehabilitation specialists, parents, community leaders and others. Although several years of WEEA funding have produced many exemplary products, gaps still exist in each discipline and at all levels of education. Without an adequate level of funding, these products are unlikely to be developed.

Although a very small program in terms of dollar amounts, the WEEA Program is making a significant contribution to educational equity throughout the country. An appropriation of $15 million for FY 1981 -- with $10 million allocated for the development, demonstration and dissemination of model projects, and $5 million earmarked for projects at the local level -- and an appropriation of $20 million for FY 1982 -- divided equally between the two programmatic goals -- will ensure that work begun under the auspices of WEEA can continue and that local areas receive useful materials as well as some incentive funds which will help them incorporate sex equity programs into their curricula.

Title IV (CRA)

The original purpose of Title IV of the Civil Rights Act of 1964 was to assist racially segregated school districts with specialized training and advice to accomplish desegregation. During the 1970's the program was broadened to offer specialized assistance in ending sex and national origin discrimination as well.

Title IV funds are carefully targeted and provide the most assistance with a small investment of federal dollars. The program offers educators and administrators the expert help they need to make necessary changes in discriminatory educational policies and practices but does not actually pay for school desegregation.

Although some other federal funds are available for race and national origin desegregation, and although some states do provide training and technical assistance for sex desegregation in vocational education under the Vocational Education Act, Title IV remains the only federal program which offers State departments of education and local school districts technical assistance and training to end sex discrimination in all areas of elementary and secondary school programs.

Under the FY 1981 Continuing Resolution, funding for Title IV was set at $45.7 million. Of that amount, $13.4 has been allocated by program administrators for training and technical assistance in the elimination of sex discrimination. We support that level of funding for FY 1981. And, we strongly recommend increased funding for Title IV for FY 1982 and, within that framework, increased allocations for sex desegregation activities.

Office for Civil Rights/USED

The Office for Civil Rights/USED (OCR) is responsible for enforcement of Title IX, Title VI, and Section 504 of the Rehabilitation Act of 1973. It is imperative that it be provided with an adequate budget to maintain a level of staffing sufficient to discharge its responsibilities promptly and thoroughly.

As the result of a lawsuit over OCR's failure to enforce the laws which prohibit sex discrimination in education filed by the Women's Equity Action League (WEAL), the National Organization of Women (NOW), the National Education Association (NEA), American Women in Science (AWIS), the Federation of Organizations for Professional Women (FOPW), and the National Student Association (NSA) in 1974, OCR is currently under court order to act promptly in responding to and investigating all Title IX complaints it receives. WEAL v. Califano, Order of December 1977, Civil Action No. 74-1720, U.S. District Court, D.C., Pratt, J.*

Current reports from the Education Department indicate that OCR is not complying with the terms of the December 1977 order. The time frames for handling complaints are missed more often than they are met, and the resolution of all cases pending or in a backlogged state in December 1977 has not yet been completed. One hundred forty-three (143) Title IX cases were unresolved as of September 30, 1980, with another twenty-six (26) cases in other categories also dating back to before December 1977. OCR has been unable to meet the Court-ordered timetables in most of the compliance review investigations, those not initiated in response to complaints. As of September 30, 1980, of the compliance reviews scheduled in the agency's 1979 Annual Operating Plan, OCR was behind schedule in 96% of its reviews. In six of the ten regional offices, OCR was behind in all of their FY 1979 compliance reviews. The record for FY 1980 is similar. Eighty-two (82) reviews approved in the Annual Operating Plan for 1980 were open on September 30, 1980; in 70% the agency had not met the time frames set by the Court.

OCR needs an authorization of no less than 1135 positions for FY 1982 to handle its current obligations and the anticipated influx of complaints in all categories. A budget of $50,971,000 for FY 1982 is crucial. Without the necessary operating funds and the human resources to staff the agency, OCR cannot meet its legal obligations.

The Effect of Education Program Consolidation on Educational Equity

Although program authorization is not within the purview of this Subcommittee, we think it imperative that each Member consider the ramifications of the consolidation on certain categorical grant programs when deliberating about the FY 1982 Education Department budget.

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*The same Order, entered simultaneously in Adams v. Califano, Civil Action No. 3095-70, also requires OCR to respond to all complaints involving discrimination on the basis of race, national origin (pursuant to Title VI of the Civil Rights Act of 1964) and handicap (pursuant to Section 504 of the Rehabilitation Act of 1973) in the same manner, as well as imposing several other obligations upon the agency.

Legislation enabling categorical grant programs provides national solutions to national education issues. Many of the federal programs whose consolidation is now proposed were enacted by Congress after studies and hearings provided overwhelming evidence of critical problems in education that were not being addressed by State and local education agencies.

It should be pointed out that categorical grant programs are available to those who seek them, and are not imposed by the Federal government on schools that do not wish to participate. The Administration has indicated that, by awarding federal funds in the form of block grants, States and local jurisdictions can rid themselves of unwarranted and unnecessary paperwork and go about the business of serving students. We would suggest that there are many ways to streamline reporting requirements that are much less drastic than eliminating vital programs.

Programs that address issues of national concern, such as sex discrimination, are most effective if they are administered at the federal level. Such a structure promotes the development of materials that have wide applicability and which can be disseminated nationally or regionally, thereby having a positive effect on target populations in a variety of settings. National programs also facilitate the exchange of creative ideas and solutions as well as the development of networks of educational personnel working to address the same or similar problems.

If WEEA and Title IV were merged with a multitude of other programs at either the State or local levels, spending for activities geared toward accomplishing the Federal goal of equal educational opportunity for female and male students would not be assured but would be left to local struggles between very weak and very powerful constituencies. A balanced approach toward achieving all of our equity goals would be lost, as would the current value of demonstration projects, nationally-coordinated development and dissemination of needed materials, and the efficient coordination and provision of technical assistance.

Additionally, WEEA supports activities at the postsecondary level and continuing education programs as well, including pre- and in-service training for teachers and administrators, and educational and career guidance for adult women students. These funds would be lost if WEEA were included in block grants for elementary and secondary education.

Block grants, wholly replacing the antecedent programs, would have the effect of eliminating the National Advisory Council on Women's Educational Programs, which was authorized as part of the WEEA legislation. This Council, supported by both Republican and Democratic administrations, has provided invaluable advice and counsel to framers of educational policy since its inception. Its loss would be difficult to overcome.

As the Administration's consolidation statement ("America's New Beginning: A Program for Economic Recovery" 2/18/81) indicates, budgets for programs such as WEEA and Title IV are small. However, their focus is broad and their potential for positive impact on all students and educators is great. Females account for over half of our population. In addition, many of the sex equity programs are designed to help overcome sex stereotyping of males as well.

We recognize that you have before you a budget proposal that rescinds 25% of the FY 1981 funds for WEEA and Title IV and provides no line item expenditure for these programs for 1982. We urge you to carefully weigh the many benefits of WEEA, Title IV and the enforcement efforts of OCR against their insignificant cost relative to the entire Federal budget. We are certain that, having done so, you will recognize that the/achievement of educational equity is worth the expense and should not be jeopardized in the interest of saving a few dollars now.

STATEMENT OF DR. THOMAS VAN DAM

I am Dr. Thomas Van Dam, Superintendent of School District 151, South Holland, Illinois. School District 151 was desegregated by Court Order with cross bussing in July, 1968 and I was appointed by the Board as Superintendent in August of that year. I believe that I am the longest tenured Superintendent in the country in a school district that was desegregated by a Federal Court Order by cross bussing. Sixty six percent of the student body in School District 151 is bussed with approximately 65% of these students bussed for desegregation purposes. The school's system lost more than one-third of its white students due to white flee out in the first year of desegregation. In 1972 Judge Julius Hoffman reluctantly agreed to the closing of two schools in the six school system resulting in the present day school organization of three schools, Pre-K to sixth grade in the white residential areas and an Upper Grade Center 7th and 8th grade in the black residential area of the school district.

At the onset of desegregation, the school system was approximately 30% black and is presently 47% black. The racial composition of the student body has remained fairly stable over the last six or seven years between 42% and 48%. The black and white residential areas have remained stable. There are a large number of private and parochial schools in or near this school district and approximately 50% of the elementary school children in the school district attend private and parochial schools. During the beginning years of desegregation, the white students who fled the district did not change residence but transferred to the private and parochial schools. Community hostility was extremely high because of the fact that neither the community or the school system was given any time to prepare for the implementation of the Court Order. No federal or state aid was made available to the school district during the 1968-69 school year until the summer of 1969 when money was made available under the old Title IV for teacher in-service training. I believe that I was one of the school superintendents responsible for changing the federal legislation to make available to desegregating school districts money for the development and maintenance of school program essential to stabilizing a desegregating school system.

In 1973 or 1974 under the then new Title VII Program which is now known today as Title VI ESAA, monies were made available to School District 151 for school program. School District 151 because of the great loss in students and the failure to pass an increase in tax rate since 1967 has been in a financial crisis for years. The financial crisis experienced by School District 151 that is now being felt by other school districts forced the Board and administration to close two schools in 1972 to reduce staff and cut program; nevertheless, the Board, administration and staff resolved to make the school program of School District 151 of top quality in order to maintain the racial stability of the school system and the community. The determination of the Board and administration to accomplish this feat has made what School District 151 is today. The Board and administration took an active role in seeing that every taxpayer in the district paid his fair share of taxes by checking the taxes paid by all of the businesses, residential and industrial properties including the railroads. The result was a more than the 10% increase in the assessed valuation and taxes received by the district. The administration and staff learned to write proposals and win grants from state, federal and private sources resulting in almost 25% of the budget supplemented by these funds. The administration and staff have become extremely adept at being able to meet many of the basic needs of educating children of wide diversity by using these needs to create proposals that followed guidelines and won grants in various areas - Ethnic Heritage, ESAA, Title I, Basic Skills, NDEA, Title II, CETA, IVB, IVC, VI and many others.

Through thirteen years of all of this, you cannot help but wonder what has the State Board of Education of Illinois done for this school district? In 1968-1970, while implementing two changes in the Court Order and suffering its greatest loss of students due to white flee out, the State Board of Education required the school district to pay back $300,000 in state aid because of the loss in enrollment. The Superintendent of Public Instruction and the state legislature did nothing in providing staff, money or aid of any kind and has done nothing above and beyond that required for all school districts in the state. Members of the state legislature and many members of Congress are most reluctant to publicly support bussing especially the cross bussing of students for desegregation purposes. Local members of the state legislature would not come out publicly seeking financial support of this school district desegregated by Federal Court Order. On the other hand, members of Congress from Illinois amd many Congressmen have time and time again gone out of their way to assist us. The school district presently receives only 15% of its revenue through state sources.

Based on this experience you can understand my deep concern that the Congress is now considering allocating funds as block grants for distribution to the states and to the local school districts rather than directly responding to proposals written by the local school districts in response to programs proposed by the federal government. In 1964-66, the black community of School District 151 appealed to the State Superintendent of Public Instruction in a formal complaint filed under the State of Illinois Armstrong Act prohibiting discrimination and after a hearing in 1966 the Superintendent's office ruled that no discrimination was taking place in the district. The same complaint and the same evidence was used by the Federal Court to desegregate the district by Court Order in 1968. In my opinion, by funneling federal funds through block grants to the state more than a 20% reduction is going to occur in the funds available to the local school districts. This district will lose an additional 10% or more when the state builds up its own bureaucracy to distribute the funds. Secondly, I worry about the local politics that will influence the distribution of funds. In the case of School District 151, there is reason to suspect that ESAA money might be diverted by state offices of public instruction or due to pressure on the school board for other than desegregation purposes. I have heard the white community ask what is in desegregation for us? Funding for Equal Educational Programs should be maintained, if possible, at the level recommended in President Carter's budget and certainly without block grants if school districts such as mine are not to lose even more funds as money filters down to us.

School District 151 has won many federal grants and my staff and I have never had problems in dealing with the Office of Civil Rights, the paper work, on site inspections or auditing funds. We have always used the funds for the purposes they were granted and our accounting system has been accurate and open for auditing at any time. Judge Hoffman has not interferred in the district after his decisions in 1968, 1969 and 1972 but he has not helped either. Two years ago the Board had to go to the State Circuit Court to win a suit against the neighborhood school group that attempted to prevent the rehabilitation of the junior high school built in 1933 in the black area with life safety funds. Judge Hoffman sat on the court order closing the two schools in 1972 until September 6th, after the bussing, staff and children room assignments were made. The order came through on Wednesday, and people were reorganized, school closed on Thursday and reopened on Friday less two buildings.

I questioned the idea that local or state school authorities will use federal funds in block grant form more efficiently or effectively if they do not have guidelines attached to them. By supplanting local funds, the federal government takes a step in more federal control of education reducing board and state responsibility for education. Supplementing local effort does increase innovation and educational change. By submitting a three year plan to the federal government, the paper work will not be any less than that required and federal entanglement at the local level will not be any less except that the state will probably also be involved increasing the burden. My colleagues in education seem to be looking for funds to do with as they please without strings attached. I cannot believe Congress, the state legislators or anyone else allocates funds in this manner.

I firmly believe you can reduce your expenditures and bureaucracy at the federal level here in Washington, D. C. Block grants to the state and local level with the reduction of funds will invite a scramble over allocation that will, in my opinion, result in the diversion and designation of money to other than intended purposes. The closer you are to the funds, the better your control over them.

STATUS REPORT

TO: United States District Court for the Northern District of Illinois
Eastern Division - Civil Action No. 68C-755

FOR: Second Semester 1980-81 School Year, South Holland, Ill., School District 151

FROM: Dr. Thomas E. Van Dam, Superintendent, School District 151

DATE February 18, 1981

RE: Second Semester Status Report, 1980-81 School Year in compliance with the May 15, 1969 Court Order as modified by Court Order dated September 7, 1972 establishing the Coolidge 7-8 Upper Grade Center, closing the Roosevelt School and Kennedy School and establishing the Eisenhower, Madison and Taft Schools as K-6 Schools.

1.0 FACULTY DESEGREGATION

1.1 Racial composition of school faculties and district personnel.

1.1.1 (Exhibit A) indicates the number of teachers and administrators in each school by grade and race;

1.1.2 (Exhibit A) also indicates the number, subject area and race of certificated district assigned faculty members as well as totals for the district.

2.0 STUDENT DESEGREGATION

2.1 Racial composition of each school's enrollment for the 1980-81 school year as of February, 1981.

2.1.1 (Exhibit B) shows student membership by race and grade per school and district.

As of February 1, 1981 the total enrollment of the district is 1,088; 574 white students (52.8%) and 514 black students (47.2%). Our enrollment reported on February 27, 1978 grades K-8 was 1,193 (55.5% white, 45.5% black). On Friday, February 5, 1979 the total district enrollment was 1,228 (Pre-K-8 grades); 638 white students (52.0%) and 589 black students (48.0%). An enrollment of 1,190 reported in February, 1980 was 639 white students (56.4%) and 552 black students (43.6%). The district's racial composition resembles that reported for the 1978-79 school year.

3.0 TRANSPORTATION

3.1 Students bussed by grade and race.

3.1.1 (Exhibit C) shows students bussed by grade and race per school and district.

3.1.2 (Exhibit C) shows that School District 151 is bussing 759 of its children; 500 or 66% of the children are bussed to desegregate the schools. Last year 65% or 514 children were bussed to desegregate the schools.

School District 151
Faculty Racial Composition

February, 1981

Grade/Subject Area	Eisenhower		Madison		Taft		Coolidge		District		Total	
	W	B	W	B	W	B	W	B	W	B	W	B
Pre-K	1		1		1						3	0
K	1		1		1						3	0
1	2		1	1	1	1					4	2
2	1	1	1		1	1					3	2
3	1		1		1	1					3	1
4	1		1		1						3	0
5		1	1	1	2						3	2
6	1		1		1						3	0
7							2	2			2	2
8							3	1			3	1
Social Worker										1	0	1
Art									1		1	0
Music									1	1	1	1
Spc 1									1	1	1	1
Special Ed.	2		1		3		1	1			7	1
Home/Sch. Coordinator									1	1	1	1
Remedial Rdg.	1			1		1	1				2	2
Parent Center Director		1		1		1	1				1	3
Physical Ed.	1		1		1		1				4	0
Librarian							1				1	0
Master Teacher	1		1			1					2	1
Psychologist									2		2	0
Title VII Dir.									1		1	0
Title 1, IVC & Curriculum Coord.										1	0	1
Parent Facilitator									1	1	1	1
Asst. Principal, Coolidge								1			0	1
Principals	1		1			1		1			2	2
Superintendent									1		1	0
Total	14	3	12	4	13	7	10	6	9	6	58	26 =
Grand Total											84	

EXHIBIT A

School District 151
Student Racial Composition

February, 1981

School		Pre-K	K	1	2	3	4	5	6	7	8	Spec. Ed.	Total	Pe (
Eisenhower														
	W	7	33	28	12	22	14	14	8			1	139	52
	B	11	12	15	23	18	15	14	16			0	124	47.
Total		18	45	43	35	40	29	28	24			1	263	
Madison														
	W	19	18	20	16	11	14	19	20				137	52.
	B	10	12	19	17	24	15	14	13				124	47.
Total		29	30	39	33	35	29	33	33				261	
Taft														
	W	13	26	19	23	26	28	32	21			2	190	53.
	B	13	16	35	22	28	19	10	13			10	166	46.
Total		26	42	54	45	54	47	42	34			12	356	
Coolidge														
	W									57	50	1	108	52.
	B									42	57	1	100	48.
Total										99	107	2	208	
District														
	W	39	77	67	51	59	56	65	49	57	50	4	574	52.
	B	34	40	69	62	70	49	38	42	42	57	11	514	47.
Total		73	117	136	113	129	105	103	91	99	107	15	1,088	

EXHIBIT B

School District 151
Transportation

February, 1981

School		Pre-K	K	1	2	3	4	5	6	7	8	Spec. Ed.	Total	
Eisenhower														
	W	3	10	12	6	9	7	3	2			2	54	3
	B	12	12	15	23	18	15	14	17			0	126	7
Total		15	22	27	29	27	22	17	19			2	180	
Madison														
	W	11	9	14	13	8	7	10	9				81	3
	B	10	11	19	17	25	14	14	13				123	6
Total		21	20	33	30	33	21	24	22				204	
Taft														
	W	6	17	14	10	14	21	15	12			1	110	4
	B	11	14	34	19	26	18	10	13			9	154	5
Total		17	31	48	29	40	39	25	25			10	264	
Coolidge														
	W									56	50	1	107	9
	B									2	1	1	4	
Total										58	51	2	111	
District														
	W	20	36	40	29	31	35	28	23	56	50	4	352	4
	B	33	37	68	59	69	47	38	43	2	1	10	407	5
Total		53	73	108	88	100	82	66	66	58	51	14	759	

EXHIBIT C

STATEMENT OF EILEEN D. COOKE

Purpose: Assistance to local education agencies through grants to states for the acquisition of school library/media center resources and instructional equipment for public and private schools. Allocation formula targets funding to those children most in need, including the disadvantaged, the bilingual, and those in sparsely populated areas.

Appropriation FY 1981:	$171,000,000 (cont. res. through 6/5/81)
Carter Budget Request FY 1982:	$171,000.000
Reagan Budget Request FY 1982:	$128,250,000 (25% cut in block grant programs)
RECOMMENDATION FY 1982:	$171,000,000

Impact of Proposed Cuts: 1. Every school district in the country would have reduced ability to provide the resources necessary to support the teaching of basic skills. Many states and localities have already cut back on the purchase of new materials. If the Reagan proposals are enacted, further cutbacks can be expected for two reasons: (A) States and localities cannot make up the difference left by reduced IV-B funding, and (B) cuts in other elementary and secondary programs will put an added pinch on school library budgets. Many school districts will elect to save a teacher's salary by cutting out the purchase of new materials.

2. A library limited to last year's materials would have no information about the new President of the United States or the release of the hostages from Iran or the home state's new Senators and Representatives. School library collection-building is not something that can be turned off in lean years if students are to be informed and literate.

3. Literacy today involves considerably more than it did in the era of the one-room schoolhouse. Besides the basic ability to read, write and compute, a literate and productive high school graduate must be able to handle job applications, armed forces equipment instruction manuals, consumer product labels, credit and interest information, and, increasingly, use of computers.

4. "The lack of literate workers is creating problems for a variety of industries -- problems ranging from wasted investment in more efficient equipment to outright safety hazards. More broadly, poorly educated workers are contributing to the U.S.'s productivity difficulties." This quote from the January 22 Wall Street Journal article, "Employers Take Over Where Schools Failed To Teach the Basics," illustrates the long range costs of reductions in library and education programs.

5. An in-depth study of twelve London, England, secondary schools to determine why students perform better in some schools than others, found a positive correlation between regular use of the school library and academic outcomes -- a higher correlation than for the amount of homework assigned or completed. (From Fifteen Thousand Hours, by Michael Rutter et al, 1979)

6. The average children's book cost $7.14 in 1979, the average reference book, $28.56. The average filmstrip cost $21.74 and the average 16mm color film $279. Hardcover books increased 24 percent over the previous year, and the price of audiovisual materials is rising rapidly because of the escalation in raw materials prices, particularly silver and petrochemicals. If IV-B were level funded for the third year in a row, it would add up to an inflation-induced cut of from one-fourth to one-third.

7. More private school children (96 percent) participate in the IV-B program than in any other federal education program. Such participation would be adversely affected by both the budget cut and block grant proposals.

COLLEGE LIBRARY RESOURCES (HIGHER EDUCATION ACT TITLE II-A)

Purpose: Provides resource development grants of up to $10,000 to institutions of higher education for library resources and for establishing and maintaining library networks.

Appropriation FY 1981:	$4,988,000 (cont. res. through 6/5/81)
Carter Budget Request FY 1982:	$4,988,000
Reagan Budget Request FY 1982:	unknown
RECOMMENDATION FY 1982:	$9,975,000

Justification: 1. Last year's extension of this program (PL 96-374) broadened the program purpose to include support of networks for sharing library resources, indicating congressional recognition of the fact that one of the few avenues open to libraries to maintain their effectiveness in supporting postsecondary coursework is through sharing expensive resources. Through newer technology, libraries can now cooperate in ways that transcend public-private sector boundaries, type-of-library boundaries, and local and state government boundaries -- making a modest federal role appropriate and necessary.

2. Individual college libraries are increasingly unable to maintain even basic collections to support student needs. The Higher Education Price Index indicates that although the cost of goods and services purchased by colleges and universities has more than doubled since 1967, the cost of books and periodicals has more than tripled. The average hardback book in economics or sociology, for instance, cost $43.57 in 1979, a whopping 47 percent increase over the previous year.

3. Because of rising prices and a growing body of literature, an academic library would need materials budget increases of 15 to 18 percent per year just to maintain equivalence. In reality an academic library may receive no increase at all, in which case the librarian is apt to continue periodical subscriptions and cut back on new books. If present trends continue, by 1990 major academic libraries would be buying no new monographs whatsoever.

4. Through computerized library networks such as OCLC, Inc. (formerly Ohio College Library Center), libraries not only share cataloging data, but have online access to the locations of items nationwide. Such advances in technology enable more intensive use of existing resources and provide access for students to needed items which may be neither appropriate nor possible for their own institution to purchase. $9.9 million (the FY 1979 level) for II-A would allow more colleges to join computerized networks and would continue the development of library resources within each state.

LIBRARY TRAINING, RESEARCH & DEVELOPMENT (HIGHER EDUCATION ACT TITLE II-B)

Purpose: Provides grants for 1) training in librarianship, 2) research and demonstration projects, and 3) special purpose grants to encourage cooperative arrangements and meet special needs.

Appropriation FY 1981:	$1,167,000 (cont. res. through 6/5/81)
Carter Budget Request FY 1982:	$2,500,000
Reagan Budget Request FY 1982:	unknown
RECOMMENDATION FY 1982:	$3,500,000

Justification: 1) Training. Minority recruitment has been a strong emphasis in the II-B training program. Of the 130,000 professionals in the library science field, only about 500 are Hispanic, about 8,000 are Afro-Americans, about 1,600 are Asian-Americans and only about 30 are Native Americans. These figures, small as they are, represent the increase of the last eleven years largely due to II-B. One program alone, the Graduate Library Institute for Spanish Speaking Americans at the University of Arizona, in four years with II-B assistance, increased the number of Hispanic librarians in the U.S. by 20 percent.

A 1975 Bureau of Labor Statistics study made an observation which is still true: "Minority recruitment efforts by graduate library schools are made considerably more difficult by the relatively low pay level in librarianship, compared to other professions...which have comparable educational requirements."

Library schools are finding that the supply of new faculty members who can teach in areas such as computer technology and newer communications media or service to special user groups like the aging is not sufficient to meet the needs. Lacking large-scale research projects typical in the science fields and undergraduate teaching-assistant taught sections that characterize some of the humanities fields, library schools find it particularly difficult to support doctoral students. HEA II-B programs have been extremely important in meeting these needs; $1 million is the minimum needed to continue.

2) Research and Demonstrations. An appropriation of $3.5 million for HEA II-B would provide $1.5 million for the only major program supporting research and demonstrations [illegible] library and information services. These projects have made an impact in two important areas -- innovative methods of extending service to minorities and other underserved groups, and adaptation of newer technologies to library operations. The needs in both these areas are great, yet funding sources are very few and very small. For every $1 million spent to maintain the public library system, only about $650 goes for public library research and development.

Most communications and data processing technologies were not developed specifically for library purposes and must be adapted to that use. Yet in few areas could a modest investment pay off so handsomely in terms of more efficient library operations and services. As libraries struggle to do more with less through resource sharing and improved methods of processing, storing, distributing and retrieving information, the need for demonstration projects is acute.

3) Special Purpose Grants. PL 96-374 transferred this program from HEA II-A to II-B and updated its purposes. $1 million would stimulate additional funding in matching grants to assist higher education institutions to meet special national or regional needs in the library and information science field, assist institutions in developing joint-use library facilities, resources and equipment, and assist academic libraries to service the communities in which they are located.

STRENGTHENING RESEARCH LIBRARY RESOURCES (HIGHER EDUCATION ACT TITLE II-C)

Purpose: Provides grants to major research libraries to maintain and strengthen their collections and to make their holdings available to other libraries whose users have need for research materials.

Appropriation FY 1981:	$6,000,000 (cont. res. through 6/5/81)
Carter Budget Request FY 1982:	$8,000,000
Reagan Budget Request FY 1982:	unknown
RECOMMENDATION FY 1982:	$8,000,000

Justification: 1. The severe problems faced by research libraries have been addressed by several study groups in recent years, including The Humanities in American Life (1980), the report of the President's Commission on Foreign Language and International Studies (1979), and Research Universities and the National Interest (1977).

The report of the Commission on the Humanities notes that the mission of research libraries goes beyond service to the institutions that pay most of their cost. "University and independent research libraries serve the nation, and support for them is in the national interest." The Commission's recommendation for II-C funding is the authorized ceiling ($15 million) for FY 1982.

2. The Commission on the Humanities also notes with dismay the deterioration of books, "a massive national problem threatening to reduce to dust within our lifetime perhaps half of the 227 million volumes held by research libraries....Preservation -- and the training in skills it requires -- may indeed be the most important and least risky investment the federal government can make in our national culture."

3. Research library expenditures for materials increased by 91 percent through the 1970s, but costs increased faster, since the number of volumes added each year to these libraries' collections decreased by 22.5 percent. The adverse foreign exchange rate makes acquiring foreign materials even more expensive. $8 million for II-C would help maintain and strengthen these libraries which provide essential support for American research, development and innovation. As one example, the University of Arizona Library at Tucson is using II-C funds to expand and share its collection of arid lands materials with researchers in other institutions. The library now possesses about 65 percent of all published arid lands information available, which it has been collecting for over 90 years.

PUBLIC LIBRARY SERVICES (LIBRARY SERVICES & CONSTRUCTION ACT TITLE I)

Purpose: Grants to states for (1) providing library services to disadvantaged persons in both rural and urban areas, (2) services to the institutionalized, (3) to the handicapped, (4) to persons of limited English-speaking ability, (5) to the aging, (6) strengthening state library administrative agencies to meet the needs of all the people, and (7) strengthening metropolitan public libraries that serve as national or regional resource centers. When appropriations exceed $60 million, a portion of the additional funds are earmarked for urban libraries.

Appropriation FY 1981:	$62,500,000 (cont. res. through 6/5/81)
Carter Budget Request FY 1982:	$62,500,000
Reagan Budget Request FY 1982:	unknown
RECOMMENDATION FY 1982:	$62,500,000

Justification: 1. LSCA I expresses a congressional concern for groups of citizens who may be out of the mainstream of public library services and thus underserved. It is an umbrella title which affords great flexibility and latitude to the states in improving library and information services.

2. A comprehensive evaluation of LSCA I for the Department of Education has just been completed. Its conclusion: "Generally, it was found that the LSCA Title I Program has contributed significantly to the development and provision of public library services. Increasingly, however, public libraries are being affected by the rising costs of services and this has diminished the capacity of the LSCA Title I Program to stimulate innovation and demonstrations. Although the Program is nearly 25 years old, there continues to be a need for the Program or one like it. Indeed, any drastic reductions in the Program could be expected to have significant and long-term effects, especially in those States highly dependent upon these funds."

3. The impact of any cuts in LSCA would indeed be immediate. LSCA is not advance funded. Since FY 1981 funding is available only through June 5, the Education Department has prorated allocations to the states and will provide only 72 percent of the funds until Congress makes a further decision on FY 1981 funding. Many states have already been affected. The Oregon State Library expects to run $110,000 short for the first six months of the year; to cope it has eliminated its $80,000 book budget and imposed a job freeze. The state is in no position to help out; it has already slashed the library's budget 15 percent.

4. Loss of LSCA monies and limited state support affect local libraries as well, especially metropolitan libraries serving as regional resource centers. The Michigan State Library's budget is down 47 percent with a loss of 35 positions and a cut of $500,000 in assistance to Detroit Public Library. The Detroit cut has resulted in lay-off notices to 20 staff. A rotating group of 4 branch libraries will be closed each month; branch libraries will buy no new books.

5. In California, inflation and Proposition 13 have caused library income in real dollars to decline 19 percent. The number of main and branch libraries is down 8 percent, hours of library service down 14 percent, and FTE staff down 10 percent. The inability of many California libraries to acquire materials may be a factor in slumping circulation, down at least 10 percent.

6. The New York Public Library has drastically cut staff and hours of its six Learner's Advisory Centers, Job Opportunity Center, and four outreach programs in poor neighborhoods. In Buffalo, the Library's Adult Independent Learner effort has been cancelled and service to persons in homes for the aged withdrawn. Next on the cut list are service to public and parochial schools and job information services.

7. Many public librarians have noted that when the economy worsens and unemployment rises, use of libraries increases, often at the very time hours and services are reduced. "Libraries haven for the unemployed," an Associated Press story headlined in December. Public librarians in Atlanta, Albany, Chicago, Detroit, and Little Rock told AP that more and more people were asking for out-of-town newspapers and resume guides. "We actually had two people get in a fistfight over the Houston paper's want ads," said a Detroit librarian.

8. "The public library is the single most important cultural institution in most communities, and preserving its vitality is unequivocally in the national interest," concluded the 1980 report of the Commission on the Humanities, in recommending increased federal support. LSCA I does this in ways which not only enrich people's lives but increase their productivity. Recent uses of these funds include establishing library service in a prison (in Brooklyn, with funds from LSCA, Consolidated Edison, and a citizen's group), placing large-print collections in nursing homes and senior citizen centers and starting books-by-mail service to the homebound (in Palm Beach, Florida), taking energy information to the people via a "Rural Energymobile" (in Minnesota), and purchasing Kurzweil Reading Machines, a truly remarkable invention which allows the blind to hear the printed page (in Iowa and Maryland).

PUBLIC LIBRARY CONSTRUCTION (LIBRARY SERVICES & CONSTRUCTION ACT TITLE II)

Purpose: Grants to states for public library construction, defined as the construction of new public library buildings and the acquisition, expansion, remodeling, and alteration of existing buildings for use as public libraries. Remodeling to remove architectural barriers and to conserve energy are priorities added in the LSCA Amendments of 1977.

Appropriation FY 1981:	-0-
Carter Budget Request FY 1982:	-0-
Reagan Budget Request FY 1982:	unknown
RECOMMENDATION FY 1982:	$50,000,000

Justification: 1. A national inventory of public library space needs was conducted in 1980. Although state-by-state data is still being processed, state library agencies reported that a total of 2,811 public library building projects are needed over the next five years, with 557 of these projects needed in 1982. The funding needed totals $2.3 billion over the period 1981-85, with $429 million needed in 1982.

2. Each federal dollar under LSCA II stimulated well over $2 in state and local support for public library construction projects. This represents an overall support level of 71 percent from nonfederal sources, and testifies to the effectiveness of the LSCA program in stimulating matching support.

INTERLIBRARY COOPERATION (LIBRARY SERVICES & CONSTRUCTION ACT TITLE III)

Purpose: Grants to the states for the planning, establishment and maintenance of cooperative networks of libraries at the local, regional or interstate level.

Appropriation FY 1981:	$12,000,000 (cont. res. through 6/5/81)
Carter Budget Request FY 1982:	$15,000,000
Reagan Budget Request FY 1982:	unknown
RECOMMENDATION FY 1982:	$15,000,000

Justification: 1. ALA supports the budget request of $15 million and agrees with the rationale given: "The increase in this program is designed to build a network of library resources whereby the collections in one library are readily accessible to users of other libraries. This emphasis follows a recommendation of the recent White House Conference on Library and Information Services."

2. Delegates (2/3 of whom were lay citizens) to the November 1979 White House Conference on Library and Information Services called specifically for federal and state support of library networks and for additional funding for LSCA III. They noted that "resource sharing is now mandated by the information explosion, the advance of modern technology, the rapidly escalating costs of needed resources, and the wide disparity between resources available to individuals by reason of geographic location or socio-economic position."

3. The strain on the nation's library budgets is severe. The average hardback book cost $23.96 in 1979, a 24 percent increase over the previous year. The average U.S. periodical subscription cost $30.37; when the institutional or library rate for periodicals is taken into account, the average subscription cost $48.37. Faced with these increases plus higher energy costs and a pending 32 percent increase in the library postal rate, libraries have had to reduce their purchases of new materials with the hope of borrowing items in lower demand.

4. A USOE funded evaluation study issued in 1978 indicated three important contributions of LSCA III: (1) greater centralization of planning and administration of library services at the state and regional levels, (2) playing a major role in influencing state legislatures to modify or pass legislation favoring cooperation and networking, and (3) providing the impetus for participation in intrastate and multistate cooperative/networks, and for increased use of telecommunications.

5. LSCA III has enabled libraries to create networks linked through such traditional devices as the telephone and the mails, but more importantly to explore and establish effective linkages via teletype, telefacsimile, and satellite telecommunications. Each of these modes offer possibilities for reaching groups that might otherwise remain "information poor:" teletype for the deaf, satellite for the rural, and telefacsimile for the confined.

OTHER PROGRAMS

NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE (NCLIS)

The American Library Association supports the authorized amount, $750,000 for NCLIS for FY 1982. NCLIS is the source for both Congress and the President of independent and objective evaluations of various aspects of library and information resources and services. The recommendations for improvement of these services made by the delegates (2/3 were citizens not connected with libraries) to the November 1979 White House Conference on Library and Information Services comprise an agenda which could fully occupy NCLIS for some years to come. Many of the recommendations (such as locating certain federal information dissemination activities in libraries) could be implemented without legislation and at very modest cost if NCLIS were operating at its full capacity.

NATIONAL LIBRARY OF MEDICINE

The Carter budget for the National Library of Medicine recommends an increase from the FY 1981 level of $45.5 million to $47.7 in FY 1982. However, within this total, the Carter budget requests a cut in the Medical Library Assistance Act from $9.8 million to $8.9 million. The American Library Association supports the request of $47.7 million for the National Library of Medicine, but recommends that an additional $900,000 be added, or preferably an additional $1.4 million which would be needed to enable Medical Library Assistance Act programs to continue at the same level of support.

The Medical Library Assistance Act supports a regional medical library network by contract with ten leading academic medical institutions. This arrangement is noted as a model of a nationwide network of libraries working together to provide a sharing of resources. The network provides the expertise of staffs as well as collections, an efficient, well-organized interlibrary loan system to provide timely information not available locally, consultative services for smaller libraries, continuing education opportunities for nonprofessional library personnel, extensive cooperation between academic and hospital libraries, and encouragement of cooperative services among hospital libraries.

MLAA also supports several small but significant grant programs, including resource development grants. Small hospital libraries are hard pressed to keep up with rapid changes in the medical field, but as a consortium, such as the Health Sciences Libraries of Central Georgia, they can share library materials, access to computerized information retrieval systems, and may even share a traveling medical librarian. MLAA provided seed money for new library centers or new services. Another example is the Community Health Information Network established between the Mount Auburn Hospital in Cambridge, Massachusetts, and six public libraries. MLAA funds provided professional health sciences literature to local health care professionals through the public library. LSCA funds have enabled public library reference staff to provide health information to the public -- a small investment now which may prevent costly medical problems later.

NATIONAL CENTER FOR EDUCATION STATISTICS

The American Library Association supports the library survey program of the National Center for Education Statistics, and urges Congress to provide adequate funding to NCES to enable it to continue its important surveys of public, academic, school, state, and special libraries as well as its surveys of library networks, library personnel, and the planned survey of research libraries. The data on libraries provided by NCES are used not only by government agencies and congressional committees, but by state and local library administrators and education and community planners, library associations, students and researchers. For these groups, NCES is the only official source of comprehensive and continuing statistics on library finances, collections, staff and services.

SCHOOL LIBRARY RESOURCES AND INSTRUCTIONAL MATERIALS (ESEA IV-B)

Purpose: Assistance to local education agencies through grants to states for the acquisition of school library/media center resources and instructional equipment for public and private schools.

Appropriation FY 1981:	$171,000,000 (cont. res. through 6/5/81)
Reagan Revised Request FY 1981:	$128,250,000
Reagan Budget Request FY 1982:	$128,250,000 (25% cut in block grant programs)
RECOMMENDATION FY 1981:	$171,000,000
RECOMMENDATION FY 1982:	$171,000,000

Impact of Proposed Cuts: Private school participation in ESEA IV-B runs over 96%, higher than any other education program. The cuts would cause this rate to drop immediately because the amount going to each school would be so low that many nonpublic schools would cease to participate. The combination of inflation and cuts would produce a drop in purchasing power for IV-B of at least 35% each year. Every school district in the country would have reduced ability to provide the resources necessary to support the teaching of basic skills. Many states and localities have already cut back on the purchase of new materials. A library limited to last year's materials would have no information about the new U.S. President or the release of the hostages from Iran. An independent study of IV-B in Indiana produced this typical response: "The ESEA IV-B program is the easiest of all to handle at local level....less delay, less red tape, and less 'MICKEY MOUSE'....don't louse it up!"

State	Estimated IV-B Expenditure FY 1931	After Reagan 25% Cut FY 1982	State	Estimated IV-B Expenditure FY 1981	After Reagan 25% Cut FY 1982
AL	$ 2,955,906	$ 2,216,930	MT	$ 616,102	$ 462,077
AK	366,892	275,169	NE	1,190,669	893,001
AZ	1,855,229	1,391,422	NV	519,187	389,390
AR	1,657,938	1,243,454	NH	678,405	508,804
CA	16,188,256	12,141,192	NJ	5,537,996	4,153,497
CO	2,042,136	1,531,602	NM	1,031,452	773,589
CT	2,325,958	1,744,469	NY	13,142,357	9,856,768
DE	449,962	337,472	NC	4,285,025	3,213,769
DC	467,268	350,451	ND	512,265	384,199
FL	5,818,357	4,363,768	OH	8,345,068	6,258,801
GA	4,084,272	3,063,204	OK	2,076,749	1,557,562
HI	695,711	521,783	OR	1,775,620	1,331,715
ID	702,633	526,975	PA	8,587,356	6,440,517
IL	8,663,503	6,497,627	PR	3,004,363	2,253,272
IN	4,264,257	3,198,193	RI	695,711	521,783
IA	2,229,044	1,671,783	SC	2,360,571	1,770,428
KS	1,692,550	1,269,413	SD	536,493	402,370
KY	2,710,157	2,032,618	TN	3,291,647	2,468,735
LA	3,364,333	2,523,250	TX	10,300,673	7,725,505
ME	858,389	643,792	UT	1,121,444	841,083
MD	3,225,883	2,419,412	VT	387,660	290,745
MA	4,291,947	3,218,960	VA	3,914,671	2,936,003
MI	7,431,299	5,573,474	WA	2,834,762	2,126,072
MN	3,163,580	2,372,685	WV	1,391,422	1,043,567
MS	2,066,365	1,549,774	WI	3,675,845	2,756,884
MO	3,596,236	2,697,177	WY	325,357	244,018

COLLEGE LIBRARY RESOURCES (HIGHER EDUCATION ACT TITLE II-A)

Purpose: Provides resource development grants of up to $10,000 to institutions of higher education for library resources and for establishing and maintaining library networks.

Appropriation FY 1981:	$4,988,000 (cont. res. through 6/5/81)
Reagan Budget Request FY 1982:	-0-
RECOMMENDATION FY 1982:	$9,975,000 (FY 1979 funding level)

Impact of Proposed Program Elimination: Last year's extension of this program broadened the program purpose to include support of networks for sharing library resources, indicating congressional recognition of the fact that one of the few avenues open to libraries to maintain their effectiveness in supporting post-secondary coursework is through sharing expensive resources. Through newer technology, libraries can now cooperate in ways that transcend public-private sector boundaries, type-of-library boundaries, and local and state government boundaries -- making a modest federal role appropriate and necessary. HEA II-A grants are in effect block grants to the states for higher education resources which benefit all citizens. But because the grants go directly to the eligible institutions, none of the funds need be used for administration, and there is a maximum of local flexibility and control. The funds help offset rising costs -- the average economics or sociology book, for instance, cost $43.57 in 1979, a whopping 47 percent increase over the previous year. The impact of zero funding on the states is shown below based on FY 1980 grants.

State	No. of Eligible Institutions	Estimated Amount State Would Lose	State	No. of Eligible Institutions	Estimated Amount State Would Lose
AL	59	$ 112,100	MT	17	$ 32,000
AK	11	20,900	NE	24	45,600
AZ	27	50,900	NV	8	15,200
AR	25	47,500	NH	24	44,300
CA	192	363,700	NJ	46	87,400
CO	25	51,300	NM	20	38,000
CT	40	76,000	NY	198	374,950
DE	10	19,000	NC	98	186,200
DC	14	26,600	ND	15	28,500
FL	79	150,100	OH	105	199,500
GA	72	136,800	OK	38	72,200
HI	12	22,800	OR	35	66,500
ID	9	17,100	PA	148	281,200
IL	112	212,800	PR	31	58,500
IN	49	92,270	RI	15	28,500
IA	56	106,400	SC	51	96,900
KS	44	83,600	SD	20	37,700
KY	35	66,500	TN	48	91,200
LA	24	45,600	TX	113	214,700
ME	26	49,400	UT	9	17,100
MD	45	87,400	VT	20	36,700
MA	99	187,450	VA	73	138,700
MI	80	152,000	WA	43	81,700
MN	51	96,000	WV	23	43,200
MS	42	79,800	WI	76	144,400
MO	52	98,800	WY	8	15,200

PUBLIC LIBRARY SERVICES (LIBRARY SERVICES & CONSTRUCTION ACT TITLE I)

Purpose: Grants to states for (1) providing library services to disadvantaged persons in both rural and urban areas, (2) services to the institutionalized, (3) to the handicapped, (4) to persons of limited English-speaking ability, (5) to the aging, (6) strengthening state library administrative agencies to meet the needs of all the people, and (7) strengthening metropolitan public libraries that serve as national or regional resource centers. When appropriations exceed $60 million, a portion of the additional funds are earmarked for urban libraries.

Appropriation FY 1981: $62,500,000 (cont. res. through 6/5/81)
Reagan Budget Request FY 1982: $46,875,000
RECOMMENDATION FY 1982: $62,500,000

Impact of Proposed Cuts: A just completed evaluation of LSCA I for the Education Department concluded that the program has made significant contributions and continues to be needed; "any drastic reductions in the Program could be expected to have significant and long-term effects." The impact of a 25% cut in LSCA I would indeed be immediate. LSCA is not advance funded. Since FY 1981 funding is available only through June 5, ED has prorated allocations to the states and will provide only 72% of the funds until Congress makes a further decision on FY '81 funding. Many state libraries have already been affected, especially those which provide essential public library services to sparsely populated areas. Oregon, for instance, has eliminated its $90,000 book budget and imposed a job freeze in order to cope with the shortfall.

State	Estimated Allocation Based on $62.5m	After Reagan 25% Cut FY 1982	State	Estimated Allocation Based on $62.5m	After Reagan 25% Cut FY 1982
AL	$ 1,072,405	$ 809,759	MT	$ 382,531	$ 327,578
AK	296,180	267,224	NE	567,168	456,629
AZ	755,316	588,133	NV	355,853	308,932
AR	707,109	554,439	NH	403,358	342,135
CA	5,421,793	3,849,719	NJ	1,912,048	1,396,619
CO	833,242	642,599	NM	484,327	398,728
CT	929,183	709,659	NY	4,352,816	3,102,571
DE	336,664	295,520	NC	1,503,693	1,111,204
DC	357,024	309,750	ND	352,811	306,806
FL	2,226,797	1,616,610	OH	2,711,441	1,955,347
GA	1,387,622	1,030,077	OK	865,302	665,007
HI	411,081	347,533	OR	773,803	601,054
ID	406,401	344,262	PA	2,952,709	2,123,979
IL	2,829,852	2,038,109	PR	950,016	724,216
IN	1,460,635	1,081,108	RI	418,101	352,440
IA	880,045	675,311	SC	879,109	674,657
KS	749,231	583,880	SD	361,470	312,858
KY	1,016,710	770,831	TN	1,213,984	908,714
LA	1,130,909	850,649	TX	3,253,183	2,333,993
ME	455,544	378,610	UT	508,197	415,411
MD	1,170,691	873,555	VT	313,965	279,655
MA	1,550,496	1,143,916	VA	1,411,492	1,046,760
MI	2,348,484	1,701,662	WA	1,087,616	820,391
MN	1,141,673	858,173	WV	635,500	504,389
MS	763,740	594,021	WI	1,295,889	965,961
MO	1,334,267	992,785	WY	299,456	269,514

STATEMENT OF MARJORIE DE BLAAY

Good morning, I am Marjorie De Blaay and I am the mother of a nine year old son who has autism. I am the Chairman of the National Affairs Committee of the National Society for Autistic Children (NSAC) and am here today to represent the organization. The National Society for Autistic Children is an association of parents, teahcers and other professionals dedicated to the education and welfare of children and adults with autism. There are 160 chapters across the United States representing the interests of some 300,000 children and adults with autism.

Autism is a neurological disorder which affects an individual's behavior and ability to communicate. It occurs in approximately 15 of every 10,000 births --Kanner syndrome or classic autism is five in 10,000. For education purposes, 15 in every 10,000 is more appropriate (Wing, 1979)--and is four times more common in males than females. Individuals, with autism have abnormal responses to sensation. Any one, or a combination of sight, hearing, touch, pain balance, smell and taste is affected. Speech and language are also affected, being either absent or delayed, even while specific thinking capabilities may be present. This frustrates not only the autistic individual's efforts to communicate, but also the efforts to communicate with them. Relationships are also affected and autistic individuals often relate in abnormal ways to others, objects and events.

This disorder has been found throughout the world in families of all racial, ethnic, and social backgrounds. There is no cure for autism, but various treatments including highly structural, skill-oriented training tailored to the individual, has proven most helpful. Diet and medication can sometimes help in types of autism where metabolic abnormalities can be identified. But still, little is known about the causes of autism and individuals are affected to varying degrees.

In past years, testimony to this committee by NSAC has focused on particular legislative issues and line item dollar figures, rather than on specific information about autism. Since testimony this year had to be prepared before the President's line-item budget was available, it seemed an appropriate time to share with you information about what autism is, and relate it to the general concepts which are being proposed by the Administration.

Two of the programs which are most important to NSAC, Education and the Developmental Disabilities Program, are slated to be included in block grants. President Reagan has said that "We will continue to fulfill the obligations that spring from our national conscience. Those who through no fault of their own must depend on the rest of us, the poverty stricken, the disabled, the elderly, all those with true need, can rest assured that the social safety net of program they depend on are exempt from any cuts." While it would probably be difficult to find many citizens who wouldn't agree that federal assistance program management needs to be improved, simply block granting various semi-related assistance programs will not ensure the continuation of a social safety net, and in fact will result in gaping holes for handicapped children.

Education Issues

Parents of handicapped children, handicapped individuals who come through the public school system, and other advocates fought hard for enactment of the Education of the Handicapped Act and P.L. 94-142. Now the Secretary of Education intends to seek repeal of P.L. 94-142, and in the meantime to block the money, along with Title I, Emergency School Aid, Basic and Secondary Education for Adults and School Libraries and Instructional Material, and decreasing their funding 20%. Originally, the Bilingual/Bicultural Program was included in this block grant to local education agencies, but representatives for that group have succeeded in convincing the Administration that the program is too important to be a part of the block grant concept. Are handicapped children any less important? Does the development of School Libraries and Instructional Materials compare in importance to the development of appropriate education programs that will help every autistic child maximize their potential?

The education laws which protect the handicapped are important to all disability groups. They are particularly important to the autistic. We are not a group that large enough to have much clout in any one state or local jurisdiction. Misunderstanding that autism is an emotional disorder still hinders the development of appropriate educational programs for autistic individuals in many states. After years of work by the National Society for Autistic Children we convinced the Department of Education this year to have autistic programs out of the program category of emotionally disturbed. This proper recognition at the Federal level that autism is a neurologically based disorder gave new hope this fall to parents of autistic children around the country. Is that hope now to be dashed? Do we have to go through that fight all over again--in every local school district in the country? And would we have a chance to win it when there are school districts with personnel who contend that there are no autistic individuals in their district and that there never will be!

And what will happen to the individualized programming that is so important to autistic individuals if there is no P.L. 94-142 and Individualized Education Plans? Because autism is a syndrome with many different probable causes, and affects individuals in varying degrees, it is important that their educational program be geared to meet their specific needs.

Autistic individuals, in order to progress, often need specialized support services as well. Because of their severe communications problems they need intensive speech and language programs, or when there is no speech training in the use of sign language. Occupational therapy is often needed to improve their motor coordination.

The law as it is now written is needed by autistic children, and greater funding, not less. Stronger enforcement too, not less, is needed. The Children's Defense Fund published a report last spring by the Education Advocates Coalition in which they said "Hundreds of thousands of handicapped children nation wide have been denied essential services because of state and local education agencies' noncompliance with the Education for All Handicapped Children Act and the concomitant failure of the federal Bureau of Education for the Handicapped to enforce the Act. Some children are being excluded from basic services; others are placed in programs wholly inappropriate to their needs." Autistic children, because of the failure of local school districts to recognize their disability, are often those who are placed in inappropriate programs to meet their needs.

My nine year old son Michael, is an example of how appropriate educational programming can help an autistic child. Michael entered public school for the first time only 2½ years age when he had just turned seven. Up until that time he had been in a program based on the theory that autism is an emotional disorder and his school day consisted primarily of a type of play therapy. I knew he was ready for more.

He entered a highly structured, classroom with four students and a teacher and an aide. The teacher started with trying to get him to recognize the difference between the letter A and B. By Christmas he knew the alphabet through S. Now, two and a half years later, he is working at only a year to a year and a half behind his normal grade level. Like some autistic children he has a fantastic rote memory, but he still has difficulty generalizing the information he has learned in his school setting to other situations.

While Michael still has great difficulty with articulation, his speech and language has improved greatly and he can now communicate most of his thoughts and feelings to his family and friends. It has made all the difference in the world to us at home to have a child who now not only responds to what is said to him but who is no longer continuously frustrated by an inability to communicate.

From an educational administrator's view, Michael is a child who will no longer cost the school district so much money. Next year, because of his progress, he will be moving into a classroom with a higher pupil-teacher ratio. Michael has won and the school district has won because the appropriate educational program was there.

Not all autistic individuals have been as fortunate as my son. For them, and even to some extent for my son depending on his future progress, the proposal to block grant the DD program is inappropriate. The DD state program (the State Grant and P and A) is different from all other 30 plus programs slated to make up the block grants. It is a formula grant to states for planning an systems change. Most of the others (a) target funds to state governments for individual entitlements (i.e. Title XX, Social Services, Material and Child Health SSI Children's program, etc.); and (b) fund local agencies and facilities (i.e., high blood pressure and veneral disease clinics). None of the others are grants to states which permit the flexible tailoring of programs to meet the needs and priorities of individual states as is the DD program.

Developmental Disability Issue

The DD program is important because it addresses the needs of the most severely and profoundly handicapped who frequently are not served by generic and specialized services. The DD population has been subject to abuse and neglect without a focus within state government to plan for, monitor and evaluate services. Congress understood well when it passed the act that severely handicapped are usually the last to be served. Recognizing that states historically had "warehoused" the developmentally disabled in expensive institutions, the DD Act emphasized that it is in the national interest to protect our most valuable citizens through federal protections and funds. Block granting the program, with no requirements to use the funds for the DD population will probably result in some states dropping it all together.

The DD program has been successful. This was well documented in the recent report submitted to Congress in January as required under P.L. 95-602. The State Formula Grant and P and A System combined cost only $51 million per year. Part C funds have generated millions more for services through private matching of seed grants as well as through capacity-building activities. There is no justification for turning away from this successful program simply because of the small economics involved.

Research Issues

The National Society for Autistic Children is pleased that the administration supports essential biomedical research activities as a vehicle for stimulating scientific breakthroughs that "return benefits to society far in excess of the federal committement of funds." But NSAC is concerned that while both Houses of Congress, in reports of their respective Appropriations Subcommittees on HEW-Labor, asked NINCDS to direct an effort toward much-needed research into the causes and cure of autism, NINCDS has still failed to staff a section on autism. They have made only modest efforts to find a pediatric neurologist to serve as section chief. Yet other disciplines could qualify for the position. All other sections in the Developmental Neurology Branch of NINCDS have implemented a research program.

For NSAC, research into the causes and a cure for autism is our number one priority. Only when we understand and can prevent the disorder will we end years of wasted lives, eliminate the need for individual families spending a fortune to find a correct diagnosis and seeking treatments that will help, and easing the stress for families whose lives have been severely disrupted by an autistic family member.

You in Congress are faced with budget proposals that call for large reductions in federal spending. President Reagan has promised, as I noted earlier, that his budget proposals would exempt programs that make up the Social Safety net from budget cuts. Yet dismantling the education program for the handicapped and the Developmental Disabilities program will remove the "spot light" from these issues and make it more difficult for the 300,000 autistic individuals around the country to receive appropriate services. You cannot forget these laws were passed for a reason--the states were not meeting handicapped individuals needs. A rational committment was needed. And it is still needed. My son has made much progress in the past. He still has a long way to go. It may seem like a lot of money, but what if Michael were your son?

STATEMENT OF MARTIN A. ADLER

We are again privileged to be asked to testify on behalf of the basic human needs and rehabilitative desires of the deaf-blind youths and adults of the United States.

My name is Martin A. Adler, M.S.W., A.C.S.W., Director of the Helen Keller National Center for Deaf-Blind Youths and Adults. Our main facility, constructed five years ago, is located in Sands Point, New York; and our nine regional offices are located in Boston, New York, Philadelphia, Chicago, Atlanta, Dallas, Denver, Seattle, and San Francisco. I am accompanied today by Dr. Robert J. Smithdas, Director of the Center's Community Education Department. Dr. Smithdas has been deaf-blind since the age of four.

The Helen Keller National Center for Deaf-Blind Youths and Adults is operated by The Industrial Home for the Blind (IHB) under an agreement signed in 1969 with the United States Department of Health, Education and Welfare. The authorization for its operation is contained in Section 313, Title III, of the Rehabilitation Act of 1973, as amended, and funds for its operation are appropriated annually by Congress. In the agreement dated November 12, 1969, it was stated that "WHEREAS, the purpose of the Center is to demonstrate methods of providing specialized intensive services, as well as other services required to rehabilitate handicapped individuals who are both deaf and blind; to demonstrate methods of training the professional and allied personnel needed to adequately staff facilities specially designed to provide such services and training of personnel who have been or will be working with the deaf-blind; to conduct research in the problems of rehabilitating the deaf-blind, and to conduct related activities which will expand or improve the services for or help improve public understanding of the problems of the deaf-blind."

As a result of that agreement, the following objectives were formulated and over the past several years have been recognized as the mandate for the Helen Keller National Center:

1. To provide initial assessment of physical and psychosocial functioning of deaf-blind individuals to determine feasibility for admission to the Helen Keller National Center, or referral to other agencies with services appropriate to their individual needs.

2. To provide multidisciplinary evaluation of those deaf-blind individuals for whom rehabilitation is feasible, and to assess their rehabilitation needs, interests, and potentialities.

3. To provide comprehensive individualized rehabilitation training to achieve in each case (a) meaningful contact with the environment and effective means of communication, (b) constructive participation in the home and community, (c) initial or enhanced employability, and (d) any other development important to the optimum rehabilitation of the deaf-blind individual.

4. To act as a resource center for the deaf-blind, the families and friends of deaf-blind individuals, and professionals in the field who work with the deaf-blind.

5. To identify and locate youths and adults who are deaf-blind in order to develop a national register. These individuals can provide information as to the composition and distribution of the deaf-blind population that will aid in the planning of services appropriate to the needs of this population.

6. To encourage and develop research regarding the implications of deaf-blindness and the impact this disability has for the deaf-blind in terms of personal adjustment, employment, education, and technical accessibility requirements.

7. To innovate and/or improve techniques of rehabilitation that will best serve the deaf-blind.

8. To design and/or improve sensory aids to help reduce the handicapping effects of deaf-blindness.

9. To provide training for workers in the field of deaf-blindness.

10. To provide community education programs designed to sensitize both the lay and professional communities to the special needs and aspirations of deaf-blind individuals.

11. To encourage, assist, and educate public and private agencies to develop and increase services for deaf-blind individuals.

To achieve these objectives, we have developed four separate elements of service within the Helen Keller National Center.

I. REHABILITATION SERVICES

Purpose --- All individuals accepted for evaluation and rehabilitation at the Helen Keller National Center are deaf and blind and frequently multi-handicapped. The overall purpose is to provide those individuals who generally have been isolated and ignored for many years with a comprehensive evaluation and rehabilitation program consisting of a thorough understanding of that individual's current abilities and potentiality. We provide training in communication, education, daily living skills, mobility, industrial arts, prevocational activities, home and personal management, personal hygiene, speech therapy, audiological services, and complete counseling opportunities. Because our individuals are deaf-blind, without sight and sound and frequently without speech, we have no other alternative but to provide services almost on a one-to-one basis. The intensity of the intellectual and emotional effort required from staff to work with our deaf-blind trainees is demanding.

The Center has a maximum capacity at the present time of 52 trainees. During the past year, we provided training for 83 clients. Some clients remain at the Center for as long as two years. Depending upon their abilities, our initial goals may be to teach deaf-blind individuals that they have names and teach them simple methods of caring for themselves out of institutions, or into boarding homes, or returning to live with their own families. Other trainees may become so skilled that they may be able to be accepted into competitive employment. One of the ten 1980 Outstanding Handicapped Federal Employees was a Helen Keller National Center graduate. A 26-year old woman began competitive employment as a medical technician in a hospital in Denver; while another woman began competitive employment as a teacher's aide in Sulphur, Oklahoma. Fees are provided generally by state agencies that refer the trainees. Our current fee schedule is $75 per week for room and board, $100 per week for each of the ten weeks of evaluation, and $65 per week for ongoing rehabilitative experiences. Some state agencies are reluctant to refer deaf-blind trainees for rehabilitation. They feel that since this is a high risk population in terms of rehabilitative success, no money is worth the effort. Hence, we attempt to keep our fees on a relatively low basis.

Plans For Further Development

Our administration recognizes the high cost of providing rehabilitative care for deaf-blind individuals, even though their institutional costs might even be greater. A thorough examination of our training approach has already been instituted and systems developed for the more effective and efficient use of staff and training procedures. Curricula for many of the subject areas within the rehabilitation department have been developed that provide us with a quantifiable basis for instruction and evaluation of progress on a systematic basis. This will give us the opportunity to develop diagnostic and training programs in less time than currently exists. We are developing this approach so that we may be able to better utilize existing rehabilitative resources in the trainee's home community once we are able to determine a diagnostic and rehabilitative approach for the particular trainee. We are also preparing our staff and procedures for the influx of those deaf-blind individuals whose handicaps came as a result of the rubella epidemic of 1963-1965. Many of these children will require training programs different from the needs of the current deaf-blind. The Bureau of Education for the Handicapped indicates that there are some 6,000 deaf-blind children as a result of that epidemic. We have developed and are now formulating plans to rearrange existing bed space in our residence that will increase our occupancy rate by approximately 6 to 8 more beds. We should also note that we have complied with the very complicated regulations of the New York State Department of Social Services in regard to our residence building safety, health, and staffing patterns.

II. RESIDENCE SERVICES

Purpose --- To provide the housing and other support services necessary for the deaf-blind trainees to reside at the Helen Keller National Center and receive rehabilitation programs offered. In addition, the residence provides living quarters for workers who are receiving training in deaf-blind services at the Center, and also for residence staff. Occasionally, parents of deaf-blind individuals stay at the residence for a period of two or three days, observing the rehabilitative process. Within the residence, two apartments have been established for those trainees who are learning how to live independently. Trainees occupying an apartment are expected to shop for and prepare their own meals, continue to participate in education and rehabilitation classes and initiate their own social activities. It is indeed remarkable to see a trainee fulfilling this role when that trainee originally came to the Center as a near helpless, dependent, and unskilled person.

III. RESEARCH

Purpose --- The Center is mandated to develop research in two areas: (1) Aids and devices for the deaf-blind; and (2) techniques of rehabilitation for the deaf-blind. Most deaf-blind individuals have no way of communicating with others unless they are in physical hand-to-hand contact. They cannot use the telephone or even the standard TTY. They may not have any idea when someone is at their door, when a fire alarm goes off, their telephone is ringing, or someone is attempting to break into their living quarters.

Our Research Department developed a unit called the Tactile Communicator that will provide signals for deaf-blind individuals within their own homes. These signals could be programmed for doorbells, fire alarms, communications, and other essential lifesaving services and needs. This Tactile Communicator has been forwarded to FCC for its final approval. Prototype production of this Tactile Communicator is slated for September, 1981.

The Smith-Kettlewell Institute, in concert with NASA and the Center, has been developing the Wrist-Com. This is a wrist-worn tactile-output paging communication system for the deaf-blind intended for use by trainees at the Helen Keller National Center.

We have also developed a Magnetic Loop Communicator to enable deaf-blind individuals as a group to hear voices through their hearing aids at some distance from the Communicator.

Over the past several years, the Center and the Smith-Kettlewell Institute have developed a Telebraille System. This is an experimental prototype device using keyboard input and a single cell braille display, coupled to a telephone receiver. It will be used as a telecommunication system for the deaf-blind.

A national Directory of Agencies Serving the Deaf-Blind has been published. This has become a valuable national resource for workers in the field of services for the deaf-blind. In addition, our Research Department, in concert with our training teams, has developed and is further developing curricula guides and systems for each of our major service departments. These curricula guides provide a broad base for individualizing educational and rehabilitative approaches, quantifying and standardizing the training approach and providing the field of rehabilitation with a systematic educational and rehabilitative process in working with the adult deaf-blind. This will enable us to further develop the concept of a diagnostic center and increase the effective and efficient operation of our training program.

Our Research Department has placed 210 new names of deaf-blind on the National Register of Deaf-Blind Youths and Adults and is formulating plans to begin the transfer of computerized data on deaf-blind children throughout the country. It is anticipated that these plans will come to fruition in the winter of 1981.

IV. COMMUNITY EDUCATION

The basic focus of Community Education is to publicize rehabilitation opportunities for the deaf-blind adult and to stimulate, motivate, and excite the deaf-blind to further their own potentialities. In 1980, 67 volunteers provided 200 hours of service per week. The department conducted 33 speaking engagements, gave 72 tours to over 1,500 visitors, made 17 radio and TV appearances, and disseminated 19 articles published by Center staff. This is also accomplished through our nine regional offices covering the United States. Generally, our regional offices provide between 700 to 800 individual services to deaf-blind persons within the period of a year. The Community Education Department also provides educational services for professional workers, parents of deaf-blind, and has funded some 17 agencies that work with the deaf-blind. We seek to awaken a national understanding of the needs and potentialities of many deaf-blind individuals. In turn, this approach increases the educational and employment opportunities for deaf-blind individuals. Our future plans for this department include the development of a National Training Team that becomes operational in July, 1981 (schedule commitments have already been established from July through December, 1981). Further development includes audiovisual programs, demonstrating and highlighting the rehabilitative techniques utilized at the Helen Keller National Center, and public service announcements as to the opportunities available for deaf-blind individuals. The Community Education Department has been particularly successful in highlighting the potentialities of deaf-blind individuals, especially since the Director of the department is himself deaf-blind.

Management has cut back on administrative costs through the utilization of systems and reduction in administrative personnel and at the same time sought to increase program income from third party sources. The only third party funding source we have access to is from fees provided by the various state vocational departments. However, they are not always prone to provide fees for high-risk handicapped populations that require a longer period of time within the rehabilitative process. For example, it is less expensive to provide rehabilitation for a young blind or a young deaf person. The rehabilitative process for a deaf-blind person is much more involved and more costly. If we raise our fees too high, many states, particularly those with relatively small budgets, will not refer deaf-blind individuals. Instead, these individuals will then remain isolated in facilities frequently for the mentally retarded or receive the most cursory services in institutions or in their homes. This existed before funding for the deaf-blind became a national effort. The loss of human dignity as well as the loss to our country of perhaps more Helen Kellers, Richard Kinneys, and Bob Smithdases, coupled with the high cost of maintaining individuals in institutions is far beyond what it costs at the Helen Keller National Center, where a rehabilitative end - possible employment - is in sight for the deaf-blind trainee.

Coupled with a ceiling on program income we, like everybody else, have experienced a tremendous surge of expenses in terms of supplies and equipment.

For Federal FY 81, we proposed a budget of $4,689,426. We received a Federal appropriation of $3.5 million for Federal FY 81. In previous years we received an annual Federal appropriation of $2.5 million and our attempts to keep within that budget of $2.5 million resulted in limited service delivery programs, low salaries for professionals, high personnel turnover, and eventually unionization. With the current Federal appropriation of $3.5 million or an operating budget of $3,784,103 (including Program Income), we have been able to attract and retain a high caliber professional staff and in doing so have been able to expand our programs in rehabilitation and in developing a training team that operates on a national basis. This team provides training opportunities across the country to private and state agencies and soon will be providing training opportunities for parents of deaf-blind youths and adults. The additional monies we received have enabled us to nearly triple our training programs across the country. We have also expanded our other educational programs, most of which have been directed toward the silent, sightless, and unhearing deaf-blind persons to excite and stimulate them to enter into programs of rehabilitation so that they can become useful taxpaying citizens. We have also raised the consciousness of other professionals as to the potentialities of deaf-blind individuals by an extensive program of demonstrations, lectures, conferences, video tape, and television presentations. As a result of the additional funding we received for Federal FY 81, there has been an even greater demand for our training programs from agencies across the country requesting our funding assistance so that they could develop programs for the deaf-blind. More deaf-blind desire involvement in our rehabilitation programs.

We are submitting to the Rehabilitation Services Administration, Department of Education, a funding request of $4 million for Federal FY 82. This budgetary request is less than our previous budget request. We are taking into account, and we must admit with unwillingness, the Administration's plan to deal with the national economic problems by cutting back on some Federal funding. Our request for a Federal appropriation of $4 million is based upon our current operating needs. No program expansion has been proposed. Instead, we are maintaining a survival pattern, requesting only those additional funds necessary to maintain mandated union salaries and inflationary costs. Reduction in the $4 million appropriation would force us to eliminate non-direct service programs, such as research programs, the Community Education program, financial support of other agencies, and the National Training Team. Once we have to cutback staff that provide direct services to our trainees within the rehabilitation process, the entire program for the deaf-blind becomes a fragile affair.

May we also at this time express our concern for the proposed block grant funding concept currently being discussed. As we understand the block grant funding process, each of the states would receive monies for the handicapped. It would then be the responsibility of each of the states to distribute those funds for the various handicapped and vocational rehabilitation programs. May we respectfully point out that prior to 1969, prior to the establishment of a national funding program to provide rehabilitation services for the deaf-blind, very few deaf-blind were involved in any organized rehabilitation program.

Block granting might encourage state agencies to provide rehabilitative opportunities for those categories of handicapped individuals that provide the highest success rate or make the greatest protest. We know governmental agencies do not wish to allocate scarce monies to handicapped individuals who require more time and effort to become rehabilitated. Instead, we will find that deaf-blind individuals will again become isolated, forgotten, and will remain as they are or revert to being tax consumers rather than taxpayers. We strongly request that the Helen Keller National Center maintain its current funding relationship to this Congressional body and to the Rehabilitation Services Administration. Funding on a national basis will provide standardized training opportunities so that clients from all over the country, from poor states as well as rich states, will have equal accessibility and equal training and equal job training opportunities at the Helen Keller National Center. National funding will provide all of the states with the achievements of our Research Department, with the training and educational opportunities offered by our Community Education Department, and will provide some 6,000 deaf-blind rubella victims of the 1963-1965 epidemic the opportunity to receive rehabilitative care when they reach the age of adulthood. Can we even imagine what might happen to some of those 6,000 deaf-blind youngsters if some of them had to depend upon local resources? Our facility was built at a cost of nearly $8 million with Federal funds. The cost of duplicating the Center's facilities all over the country would be prohibitive. It is much easier, unfortunately, to place some of our deaf-blind individuals in state and county facilities that are not built or staffed to provide the safety or the rehabilitation opportunities for deaf-blind people. What about the families of those 6,000 deaf-blind children? How will we explain this problem to them?

When we read President Reagan's transcript of his State of the Union message, he said:

> "We will continue to fulfill the obligations that spring from our national conscience. Those who through no fault of their own must depend on the rest of us, the poverty-stricken, the disabled, the elderly, all those with true need, can rest assured that the social safety net of programs they depend on are exempt from any cuts .....
> I hope I've made it plain that our approach has been even-handed; that only the programs for the truly deserving needy remain untouched."

We feel President Reagan and his advisers were talking about the deaf-blind population. They are indeed "truly deserving" of services to enable them to become partners in our American society.

STATEMENT OF VINCENT GRAY

My name is Vincent Gray. I appear before you this morning representing the Association for Retarded Citizens, a national organization composed of 1,900 local and state associations with almost 300,000 members, many of whom are parents of mentally retarded children.

Mental retardation is a lifelong disabling condition with no known cures which requires, in many cases, a continuum of services throughout the life of the individual. Basic services such as special education, vocational rehabilitation, residential placements, and social and medical services are essential to prevent unwarranted and costly institutionalization and wasted lives.

The parents of the approximately six million mentally retarded citizens of our country are presently gravely concerned about President Reagan's Economic Recovery Program, which, if implemented as proposed, will drastically affect the lives of mentally retarded citizens and their families.

There is hardly a service program funded by the Federal Government currently available to mentally retarded people wherein their continued eligibility and access to the program is not at great risk or the program itself faces serious funding cutbacks. Time does not permit me to review all of our concerns today, so I will concentrate on those vital programs funded through the Department of Education.

Since 1975, mentally retarded children have benefited greatly from the enactment of the Education For All Handicapped Children Act. This Act guarantees each and every school-aged handicapped child, regardless of the severity of the handicap, a free, appropriate education. The Act assists state and local education agencies by partially financing the costs of the special education program. In 1981, through an appropriation of $922 million, the Federal share amounts to approximately $235 per child, which represents about 11%

of the average cost of special education. The passage of the Education For All Handicapped Children Act was particularly crucial to the parents of severely and profoundly mentally retarded children, most of whom had had the doors of education firmly closed to them in many states prior to the enactment of the Act. These unfortunate children are now profiting from their educational opportunities. Despite their handicaps, many are being trained to care for themselves and to contribute to society in some way in their adult years. To the parents of these children, programs such as special education are a great relief, not only in the training and skill development available to their children, but also in the hope for a real future for the children.

It is incredible to us that the President now proposes to repeal this vital Act, thereby potentially, in fact most likely, destroying the basic right to education for all handicapped children. This would be accomplished by block granting the Education For The Handicapped State Grant program and the Pre-School Incentive program to local school systems and repealing the Education For All Handicapped Children Act. In addition to repealing the law and establishing the block grants, the President also proposes to make a 25% reduction in the Federal role in financing the education of handicapped children.

Although the members of our Association clearly recognize the need to solve the economic ills of our nation, we cannot understand how the Administration expects to succeed by abolishing the right to education and reducing its commitment to educating handicapped children. Someone must realize that the withdrawal of educational opportunities for mentally retarded children will significantly enhance the likelihood of additional, much most costly, lifelong services for these people. The effects on future Federal budgets will surely be negative, to say nothing of the impact on the lives of the families of these children.

Our Association strongly rejects the Reagan Administration Block Grant proposals, particularly the one to local educational agencies and certainly opposes any reduction in Federal aid to school systems for special education of handicapped children.

We were greatly heartened by the actions of the Senate Labor and Human Resources Committee last week when it reported its recommendations to the Budget Committee for fiscal year 1982 special education and vocational rehabilitation spending levels. That Committee rejected the Reagan cutbacks, instead endorsing a 10% increase above the level recommended by the Congressional Budget Office. The Association for Retarded Citizens strongly supports this level of $1.14 billion for the Education For The Handicapped State Grant program for the fiscal year 1982 budget. This increase will allow the Federal Government to continue to reimburse school systems at approximately the same percentages as in 1981 and allows for the anticipated increase in the number of handicapped children to be served in the next school year by at least 50,000 children. We urge this Committee and the entire Congress to appropriate this $1.14 billion figure for financing education for handicapped children.

In addition to the state grant, there are several other important components to the Education For The Handicapped Act which also merit consideration. Particularly vital are the pre-school incentive grants, special population programs such as early childhood and severely handicapped projects and special education personnel development. We urge the Committee to appropriate funds for these programs for fiscal year 1982 at the same level they were funded fiscal year 1981. The recommended figures are contained in the summary page of this statement.

As important as special education is to each mentally retarded child, so is the opportunity to gain access to vocational rehabilitation services when special education is completed. For many mentally retarded persons, vocational rehabilitation services are the key to a job and independent life. On the other hand, the failure to obtain vocational rehabilitation services will likely result in the inability to get a job, leading to a lifetime of dependency on various government services to survive. The Congress has been aware for decades that the Vocational Rehabilitation Program is one of the best cost benefit programs funded by the U.S. Government. Given our current economic dilemma, allowing disabled people to become tax payers instead of tax burdens clearly should be a very high priority. Yet, the new Administration seeks to reduce funding for this valuable program. We are frankly puzzled by this short-sighted policy! In our zeal to straighten our economy, we must carefully assess the implications on the future. The ARC hopes the U.S. Congress will seriously analyse the positive impact on the economy from a sound vocational rehabilitation program.

Our Association urges the Committee to appropriate the full authorization level of $972 million for the Vocational Rehabilitation State Grant program. Taking inflation into consideration, such an increase will allow the program to maintain its present level of services.

The 1978 amendments to the Rehabilitation Act authorized the Comprehensive Services for Independent Living program to enable Vocational Rehabilitation agencies to serve our nation's severely handicapped citizens who cannot qualify for basic vocational rehabilitation services. However, the Administration's budget for fiscal year 1981 only requests funds for Part B (Centers for Independent Living) and does not request funding for Part A (Grants to States for Independent Living Rehabilitation) and Part C (Independent Living Services for Older Blind Individuals), which is dependent upon Part A funding for its own financing.

When the Congress enacted Title VII as part of the Rehabilitation Act amendments of 1978, it, along with handicapped citizens and their advocates, envisioned a substantial new service program with sufficient funds to develop effective long range plans and services.

It is important to note that the only reason Part A is not implemented is the lack of appropriated funds. The state rehabilitation agencies, which have the responsibility for program planning and implementation at the State level, have indicated a strong desire to initiate the program. Numerous demonstration projects in recent years have indicated the viability of the Independent Living concept.

The ARC recommendation for $45 million for fiscal year 1981 is justified on the basis of:

- a reasonable initiation of the Part A Comprehensive Services State Grant Program;
- the continuation of ongoing efforts with Centers for Independent Living (Part B); and
- start-up for the Part C Older Blind Individuals program.

The Part A portion of the Independent Living program has never been launched due to the unavailability of appropriated funds. If all fifty states received the minimum allotment of $200,000, approximately $10.5 million is necessary. In order to launch the program equitably in the more populous states, an appropriation of approximately $25 million is suggested. That level of funds would provide approximately one-third of the states with the minimum allotment, with the remaining, more populous states, receiving a larger proportional share.

Finally, vital efforts in Vocational Rehabilitation research and training must be continued. We support modest increases of $4.5 million to support training efforts and $5 million to enable the National Institute of Handicapped Research to meet its mandates.

SUBCOMMITTEE RECESS

Senator PROXMIRE. The committee will stand in recess until 1:30 today.

[Whereupon, at 10:55 a.m., Wednesday, March 18, the subcommittee was recessed, to be reconvened at 1:30 p.m. this same day.]

(AFTERNOON SESSION, AT 1:30 P.M., WEDNESDAY, MARCH 18, 1981)

NONDEPARTMENTAL WITNESSES

Senator BURDICK [presiding]. This afternoon we will hear testimony on the budget for the Department of Education. We have a large number of people to testify, so by necessity the time allowed for outside witnesses is limited.

In your testimony I hope you give us your highest priority for funding among the major programmatic areas. Once we have completed the fiscal 1982 budget we plan a more deliberate look at the programs under the subcommittee's jurisdiction, in preparation for the fiscal 1983 hearings.

We will begin with the testimony on the budget for rehabilitation services and the National Institute of Handicapped Research. I want to say at this time that although you are under time restraints—all statements will be made and placed in full in the record.

Because of the time factors here today, we have five panels and we are going to allot 15 to 16 minutes or so to each panel, there will be some warning lights, and instead of reading your full statement we would appreciate it if you would summarize.

I think that is more effective anyway and we will see if we can't give everybody a chance to be heard within that time period.

So I believe our first group is the rehabilitation services and handicapped research.

Introduce yourself and proceed.

STATEMENT OF JAMES G. LEDBETTER, DIRECTOR OF DIVISION OF VOCATIONAL REHABILITATION, STATE OF GEORGIA

Dr. LEDBETTER. I am Jim Ledbetter, head of the Georgia Rehabilitation Administration Agency. Vocational rehabilitation program is the oldest State-Federal program in existence.

In 1920 the impact of disability was recognized on individuals and there was a joint commitment by the State and Federal Government to help overcome the impact of those disabilities in a cost-benefit way, with a purpose of returning disabled people to gainful employment.

I would like to address the philosophy of that program and other full funding for the rehabilitation program. We all recognize the necessity to control Federal expenditures. However, I would urge that thoughtful deliberation and examination by program because the rehabilitation programs have been very cost-benefit.

This can best be described by an example of a young lady in my State who was drawing social security disability insurance and was so disabled that people indicated that she could never work, that her hands could only be used as paperweights.

Through a cooperative effort of the State rehabilitation agency, Good Will Industries, the Atlanta computer industry, and Georgia Tech, the young lady is now employed as a computer programer with Georgia Tech, making $17,000 a year. She will no longer receive SSDI benefits, she will be covered by Georgia Tech's medical insurance rather than medicaid.

As an example of the way that rehabilitation program can eliminate dependency and help individuals become self-sufficient.

Senator BURDICK. What do you call full funding?

Dr. LEDBETTER. $972 million.

Senator BURDICK. Next witness.

STATEMENT OF JOSEPH DUSENBURY, PRESIDENT, NATIONAL REHABILITATION ASSOCIATION

Mr. DUSENBURY. I am Joe Dusenbury from South Carolina and I represent the National Rehabilitation Association as its president. We have filed a full report with you and I ask that it be a part of the record.

Senator BURDICK. I have accepted all of the statements from all witnesses today.

Mr. DUSENBURY. I would then like to summarize. Vocational rehabilitation program is one of the programs which not only makes great philosophical sense but also returns tax dollars far in excess of the cost.

For every Federal tax dollar spent it is estimated that 11 or more are returned in taxes paid by those individuals. We are also one of the Federal programs of which you can be proud, for we have not suffered from fraud and abuse and mismanagement, which has been found in some of your programs.

The single most important request that we make of you today is that the committee provide full funding to the provision for rehabilitation of $972 million. This is not an enormous amount of money, as compared with so many other Federal programs, and is one of the most important you will have the opportunity to fund.

It is ironic that we are here today amidst great outcry to reduce Federal expenditures, yet a program such as vocational rehabilitation would put handicapped individuals in competitive employment that has been targeted for reduction in funding.

This country simply cannot afford to continue in this current direction as relates to handicapped individuals. We are dramatically increasing benefit programs but at the same time are reducing programs which can turn these individuals into competitive work.

That logic is totally inconsistent with the expressed desire to control Government spending and get Government off the backs of our people. By comparison the small rehabilitation program personifies exactly what we profess to see in this country, yet it is proposed that the budget ax fall equally on this program as all others whose admitted error rate exceeds our entire appropriation.

If I sound overly dramatic it is because I feel so deeply if Congress really understood what is happening, for handicapped individuals, the members would quickly greet what I am saying today. I repeat if you knew what we were doing to return people to work, you would be our greatest advocates, for I promise you that you would be proud of what we have accomplished.

It is difficult for me to remain calm and collected when I realize from my own years of experience that we are doing exactly what you wish to have done, yet we apparently have not made our programs clear.

I hope that Congress will not let us be punished because of our own modesty and because of our failure to loudly blow our own horn. Perhaps our shortcomings have been that we have not successfuly informed you of our achievement with our limited money available. This is a unique State program that is not a burden on taxpayers, but an investment on the future.

STATEMENT OF MERLE ARNOLD, PRESIDENT, HOPE ENTERPRISES, INC.

Mr. ARNOLD. I thank you for this opportunity. Hope Enterprises, of which I am the president, is a rehabilitation facility.

In order to provide all of the needed services to handicapped people, facilities have expanded their focus beyond the traditional State rehabilitation program. This focus includes programs authorized under the Rehabilitation Act, title XX, and the Developmental Disabilities Act.

The National Association of Rehabilitation Facilities cannot support the proposed 25-percent reduction in funding for rehabilitation services. We strongly urge that each program, each building block authorized by the Rehabilitation Act, be funded at the minimally adequate level outlined in my written testimony at exhibit 1, so that the compehensive rehabilitation strategy of the act can become a reality.

NARF wishes to highlight to the subcommittee the need to continue the State grant program and request funding at the full entitlement of $972 million. Furthermore, projects with industry, which has proven very successful, should be funded at $10 million in fiscal year 1982.

Furthermore, Mr. Chairman, we cannot support the proposed rescissions for fiscal year 1981 for service projects, especially those affecting independent living and the projects of industry program.

Let me also briefly mention other programs of concern to facilities. With respect to title XX, NARF recommends that the program be continued at the fiscal year 1982 entitlement level of $3.1 billion.

The Mental Health Act is a very significant act, because it addresses the needs of the mentally ill who have been on the short end of the stick for a long time. NARF recommends that the committee support the $339 million requested for this program, whether or not it is funded through a block grant.

For the developmental disabilities program, we recommend that $91 million be made available in fiscal year 1982 with the major emphasis over fiscal 1981 being in protection and advocacy and the State allotment.

I would also like to touch just briefly on the significance of the block grant. The stated justification of the administration's proposal is that aggregation of these programs, with elimination of Federal requirements, will permit savings in administrative costs and other program efficiencies sufficient to offset the funding reduction.

The administation's proposal just is not logical. Consolidation and any elimination of administrative requirements will not offset a 25-percent reduction. For example, administrative costs incurred in the State grant program already account for the use of 45 percent of the funds.

In my own State alone, the Bureau of Vocational Rehabilitation, for all intents and purposes, had no money available for services during the last quarter of last year. But the entire State system for delivering those services and all of the costs involved, were maintained throughout that quarter, while for all intents and purposes, all the services to handicapped persons stopped in the whole Commonwealth of Pennsylvania. The rehabilitation program focuses on restoring people as opposed to maintaining them and should remain separate. It has existed for over 60 years and has been successful in rehabilitating people. It should be retained at adequate levels. Thank you very much, Mr. Chairman.

Senator BURDICK. Thank you very much.

STATEMENT OF DONALD W. DEW, PRESIDENT, NATIONAL COUNCIL ON REHABILITATION EDUCATION

Dr. DEW. My name is Donald Dew, president of the National Council on Rehabilitation Education. I also serve as the director of training and research utilization at the George Washington University in Washington, D.C.

The National Council on Rehabilitation Education, which has a membership of 80 universities and represents hundreds of rehabilitation educators and researchers who appreciate the opportunity to discuss three major concerns with you.

The first is that in order to deliver the necessary services to disabled individuals in this country, we feel it is absolutely necessary to have qualified and competently trained individuals, which is the area that we are interested in.

During the past year, we have conducted a comprehensive survey of over 3,000 of our graduates from counselor education programs and producing rehabilitation counselors, evaluators, placement people, and found that 90 percent of those graduates are going to work in the field of rehabilitation.

The NCRE is requesting funding at the $30 million level for 1982. We also feel that education is a process where we are training people for the future and the funding is necessary now, in order to insure that quality services do continue in the future for the disabled citizens of this Nation.

Also, if I may, I would like to comment on the rehabilitation research and training centers which are part of the National Institute of Handicapped Research.

As I said, I also serve as director of training and research utilization at one of the centers here in Washington, D.C.

There are 24 R. & T. centers, rehabilitation research and training centers, and they have been the primary focus for research related to handicapped individuals in this country.

All of the centers are associated with major universities and have been conducting research for the past 20 years. In addition to the rehabilitation research that is being accomplished, each center has a very strong small research utilization component. Our feeling has been within the R. & T. centers that research is of very little use if it is not shared with practitioners in the field.

So that each of these programs have a major, what we feel is a strength, in terms of disseminating the research information. We are requesting that $30 million for NIHR for 1982, and we think that the R. & T. centers would receive about $16½ million.

My final comment, Mr. Chairman, is that during the past year, NCRE and the R. & T. centers have been in constant communication with organizations like NRA and our colleagues here and at both of these organizations completely support the testimony and statements given by our colleagues here.

We feel it is important that we work together and bring to you the best information that we can and by working together we will all impact hopefully on the services for the disabled. Thank you very much.

Senator BURDICK. Thank you very much.

STATEMENT OF JOSPEH L. COHEN, ESQ., UNITED CEREBRAL PALSY ASSOCIATION

Mr. COHEN. My name is Joseph L. Cohen. I am from Pittsburgh, Pa. And I am a member of the—excuse me, I am chairman of the Consumer Activity Committee of United Cerebral Palsy, Inc. I would like to just say that my statement is in the record and I do not wish to reiterate things already in the record.

I wish to support the previous panels' speakers and I wish to sort of consolidate the philosophy that I think brings us together here.

And that philosophy is that a person has to have an opportunity in life to reach his or her own potential. When I was growing up, when I was going to school, there were no services available to me such as Congress has required and enacted that are available now to aid persons with physical and mental handicaps.

I wish only to state that unless we look at this as a process, and we see that a person cannot be a productive individual, unless there is a public investment in that person to allow them to reach their potential, then society in general loses.

And it is with that purpose in mind that I come here to say don't let people enter the social system accidentally. Don't let them prosper or lack to prosper accidentally, especially when they need assistance. It is important that we keep a structure of services available so that people will reach their potential not by accident, but by design.

And unless that is realized, all of these numbers don't mean anything unless we look at this as a total process to aid individuals in a fulfillment of their potential.

And with that in mind, I would just stress the United Cerebral Palsy Association interest in education for all handicapped individuals which I think is very important because education is the bedrock of human potential.

I think it is also very important that we support the program for independent living, because not only does that program give dignity to people who otherwise would not have that opportunity, but it does give the real possibility of gainful employment to people with severe disabilities.

And third, we would like to note our support of the developmental disabilities program and I would like to say I am personally familiar with that program, having been the chairman of the first Pennsylvania Development Disabilities Council. Thank you for your time.

Senator BURDICK. Thank you.

Senator SPECTER. If I might just say a word, Senator Burdick. I came especially to hear Mr. Cohen's testimony and I regret I can't stay longer.

I would like to note from my own personal appreciation, and I am sure I reflect the appreciation of the chairman of the subcommittee and of all of the Senators in your appearance here today, Mr. Cohen, and your very moving statement on behalf of the cause which you have articulated.

I have noted your very extraordinary records and good works and Senator Burdick and I will pass the message along to our colleagues on the subcommittee and the appropriation generally, and I personally want to thank you for coming and providing that testimony.

Mr. COHEN. Thank you, sir.

Senator BURDICK. I want to thank the entire panel.

The PANEL. Thank you.

[The statements follow:]

STATEMENT OF JAMES G. LEDBETTER

The Council of State Administrators of Vocational Rehabilitation is an association composed of all of the chief administrators of the public rehabilitation agencies providing services to handicapped persons in the fifty states, the District of Columbia, Guam, Puerto Rico, the Trust Territory of the Pacific Islands, the Commonwealth of the Northern Marianas, and the Virgin Islands. These agencies constitute the state partners in the State-Federal Program of Rehabilitation Services for persons with mental and physical disabilities provided by the Rehabilitation Act of 1973, P.L. 93-112, as amended. This 61-year-old program is a major resource for, and the state rehabilitation agencies are the primary providers of, rehabilitation services to the handicapped citizens of this Nation.

In order to provide state input into the State-Federal Vocational Rehabilitation Program, the Council was established by the State Directors in 1940, on the recommendation of and with the full support of the Federal Administrator of the Vocational Rehabilitation Program. Since its inception, the Council has enjoyed a quasi-official status as an active advisor to the Federal administrators in the formulation of policy and program decisions at the Federal level, and as an active force for strengthening the effectiveness of the service programs for disabled Americans. It is also a forum for State Rehabilitation Administrators to study, deliberate, and act upon matters bearing upon the successful rehabilitation of handicapped persons and of national importance to disabled people.

The primary purpose of vocational rehabilitation services funded through the Rehabilitation Act is to render "employable" those disabled persons who, because of the severity of their handicaps, are unable to secure and hold employment. The 1978 Amendments to the Rehabilitation Act (P.L. 95-602) broaden the scope of the Rehabilitation Program by authorizing a new program of "Comprehensive Services for Independent Living." The purpose of the Independent Living Rehabilitation Program is to assist those individuals "whose disabilities are so severe that they do not presently have the potential for employment but may benefit from . . . rehabilitation services which will enable them to live and function independently." These constitute the two main thrusts of the State-Federal Rehabilitation Program today.

The Rehabilitation Act is the most complete and well-balanced legislation in the human service field. In one Act, provisions are included for a comprehensive and individually-tailored program of services to physically and mentally handicapped individuals; an innovation and expansion program; a training program; a research program; a special projects program; a rehabilitation facility program; an employment program; and a comprehensive services program for independent living. This balanced emphasis embodies the elements necessary for a successful rehabilitation program to be provided through a nationwide network of public and private service providers.

It is--bar none--the most cost effective government program in our nation's history.

BASIC STATE GRANTS: VOCATIONAL REHABILITATION SERVICES (Section 110)

FY 1982 Authorization	$972,000,000
FY 1982 CSAVR Recommendation	$972,000,000

Basic State Grants are the lifeblood of the Vocational Rehabili-Program. It is this section of the Act which funds the provision of vocational rehabilitation services to individuals with mental and physical disabilities.

These Federal dollars, matched with state money at a ratio of 80% to 20%, permits a state rehabilitation agency to provide for, or contract with, private agencies and organizations to provide individualized, comprehensive services for the purpose of rendering "employable" eligible, handicapped persons. Such services include evaluation; comprehensive diagnostic services; counseling; comprehensive physical restoration services; prosthetic devices; various kinds of training and training supplies; maintenance; placement; placement tools and equipment; initial stocks; transportation; post-employment services; placement follow-up services; and any other service needed to rehabilitate an individual into employment.

The people served by the program include people with heart conditions, blind persons, deaf persons, amputees, persons with mental disabilities, diabetics, mentally retarded persons, or any of many other chronic, disabling conditions incurred through accident, illness, or birth.

These funds may be used for the establishment and construction of rehabilitation facilities; although funds for facility construction are also authorized under Title III of the Act. The most recent statistics available are from Fiscal Year 1978, and show that over 30% of Basic State Grant monies went to provide services and support, and to encourage both public and private non-profit facilities across the country.

In Fiscal Year 1980, the $817,484,000 appropriated for Basic State Vocational Rehabilitation was used by state rehabilitation agencies to serve 1,353,476 disabled individuals, of which 252,666 were rehabilitated. Despite this expenditure, there still are not sufficient funds to serve all those eligible, disabled persons who have the potential and desire to work and who need rehabilitation services to attain employment or self-sufficiency. Alarmingly enough, our best estimate is that state rehabilitation agencies were only able, based on the FY 1980 appropriation of $817,484,000, to serve one out of every twenty people who were eligible for such services.

For the Rehabilitation Program to live up to not only its potential, but even to its past achievements, we urge both the Congress and the Administration to support this vital program in every conceivable way.

We urge the Congress to honor its legal commitment to fund this program at the "entitlement" level. Funding for the Basic State Grants program during both FY 1979 and FY 1980 was $817.484 million. This year, the Congress, in a Continuing Resolution which expires on June 5, appropriated $854.259 million for this program, an increase of approximately 4.4% over two years, which has been forced to coexist with two years of nearly-unprecedented double-digit inflation. The Carter Budget, for Fiscal Year 1982 recommends the funding of Basic State Grants at $900 million. President Reagan is recommending only $698.25 million.

The Council strongly urges that the Committee provide appropriations for Basic State Vocational Rehabilitation Services under Section 100 (b)(1) of the Act in the amount of $972,000,000, for Fiscal Year 1982. This amount, the entitlement level, is vitally needed if the program is to continue services to individuals with the most severe handicaps. Nevertheless, even this will not allow the proper fulfillment of the mandates of the Act.

Our recommended appropriation level for Fiscal Year 1982 represents an attempt to maintain the purchasing power of the program "service dollar," which has steadily eroded over the past several years due to inadequate increases in funding to meet the vast needs of severely disabled persons.

State Rehabilitation Agencies, in carrying out the mandate of the Act to give priority of service to the rehabilitation of the severely handicapped, are finding that the costs--in terms of time, effort, and money--of serving this group are great--much greater than the cost of rehabilitating the less severely disabled. This means that the program is serving fewer people, while expending more money for adequate services, adequately trained staff, adequate equipment, and adequate facilities. To illustrate, in FY 1980, the mean cost for services to severely handicapped individuals who were rehabilitated was $3,933, while the mean cost for non-severely handicapped persons was $2,622.

In these times of spiraling costs and budgetary restraints, it is important to remember that human lives and the quality of services are what we are actually talking about when discussing appropriations. The justification for higher funding levels stems from the purpose for which the money is spent--the prevention of an incalculable waste of human potential--a purpose on which no price tag can be placed. Whether the cost is hundreds of millions or hundreds of thousands of dollars, there is no other human service program whose funds are spent in such a cost-effective fashion to help people to live more self-sufficient and productive lives.

Vocational Rehabiliation has continually more than paid for itself by helping handicapped people increase their earning capacity; or by freeing some other family member to work; or by decreasing the amount of welfare payments, health services, and social services they might need; and by assisting them to become taxpayers.

Essential, of course, to the continuance of a successful program is a well-funded program of comprehensive and individualized direct services to help handicapped persons become employable. The Congress must continue to view the funds appropriated for Basic State Grants as being a sound investment of the public's money.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING (Section 731(a) Parts A,B,C)

FY 1982 Authorization	Such Sums
FY 1982 CSAVR Recommendation	$45,000,000

Title VII of P.L. 95-602 established a state grant program to provide Comprehensive Services for Independent Living designed to meet the current and future needs of individuals with disabilities so severe that they do not presently have the potential for employment but may benefit from rehabilitation services which will enable them to live and function independently.

Both P.L. 95-602 and the U.S. Senate Report envision a substantial new service program with, as the Senate Report declares, "sufficient funds" available to develop "effective long-range plans and services."

The time to implement a new Comprehensive Services Program is now. No more "demonstrations" are needed; Congressional intent clearly envisions a major new state grant program.

The CSAVR's request for a $45 million appropriation for FY 1982 for this program is justified on the basis of devising an equitable state distribution procedure for Part A Service Grants, ensuring a renewal of the I&E independent living rehabilitation projects; allowing a continued appropriate funding base for the Centers for Independent Living and funding for the first time an Older Blind Individual's Program.

For these reasons, we recommend $45 million for Fiscal Year 1982 to implement programs authorized under Parts A, B, and C of Title VII.

RESEARCH (Section 201(a)(1))

FY 1982 Authorization $100,000,000

FY 1982 CSAVR Recommendation . . . .$ 40,000,000

The Rehabilitation Act Amendments of 1978 established a National Institute of Handicapped Research, now in the Department of Education.

The Council's request of $40 million for Fiscal Year 1982 is clearly justified by the numerous new research authorities included in the Act, as well as the need to continue to support, as well as to expand, the Rehabilitation Research and Training Centers, the Research and Demonstration Projects, and the bioengineering centers. The Rehabilitation Research and Training Centers are supported at about $16.6 million now, and there are some 24 centers. Many of these centers have not had even a cost-of-living increase in the past few years.

TRAINING GRANTS (Section 304(e))

FY 1982 Authorization $50,000,000

FY 1982 CSAVR Recommendation $30,000,000

This is a time when staff competency should be strengthened to deal with new authorities in the Act and with the increased numbers of severely disabled people that the program is serving. The specialized rehabilitation professions, such as those in the areas of counseling, work evaluation, rehabilitation medicine, rehabilitation nursing, and rehabilitation facility administration, do not have long histories and, in fact, are the creations of the training programs under the Rehabilitation Act. The Council believes that these programs should continue to receive support, so that progress may continue to be made in upgrading the quality of professional services to the handicapped and to develop and support new professions which are developing with respect to providing services to severely handicapped people.

Since these training programs are critical to the field of rehabilitation, and since they receive no major support from any other source, the CSAVR recommends that $30 million be appropriated under Section 304(e) for Fiscal Year 1982.

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION RECOMMENDATIONS FOR APPROPRIATIONS FOR REHABILITATION SERVICES FOR FISCAL YEAR 1982

(in millions)

ITEM	APPROPRIATIONS FY 1981	AUTHORIZATIONS FY 1982	CSAVR RECOMMENDATIONS FY 1982
BASIC STATE REHABILITATION SERVICES			
Section 100(b)(1)	$845.75	$972.0	$972.0
Section 110(b)(2)	8.509		
COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING			
Section 731(a)	18.0	Such sums	45.0
NATIONAL INSTITUTE OF HANDICAPPED RESEARCH			
Section 201(a)(1)	35.0	100.0	[illegible]0.0
REHABILITATION TRAINING			
Section 304(e)	25.5	50.0	30.0

STATEMENT OF JOSEPH DUSENBURY

Mr. Chairman and members of the Subcommittee, my name is Joseph Dusenbury, President of the National Rehabilitation Association (NRA). On behalf of the Association, I submit the following statement in support of appropriations for programs authorized by the 1973 Rehabilitation Act, as amended.

I request that this statement be made a part of the official record.

First, Mr. Chairman, let me express the appreciation of the National Rehabilitation Association on behalf of the mentally and physically handicapped persons of this Nation and the service providers for the support given this program by you and other Subcommittee members for so many years.

The National Rehabilitation Association, with a membership of over 20,000 professionals and consumers, works and advocates on behalf of persons with disabilities. For over fifty years, NRA has tried to be a strong and aggressive advocate for rehabilitation and we sincerely welcome this opportunity to draw your attention to the needs and requirements for monies to adequately fund the Rehabilitation Program in Fiscal Year 1982.

Attached to this statement is a summary of NRA's recommendations for appropriations for these programs. We would like, however, to discuss and highlight a few of these programs and appropriations recommendations.

BASIC STATE VOCATIONAL REHABILITATION SERVICES (Section 100(b)(1))

Mr. Chairman, there is one request paramount to all that is to follow--that is, the request for adequate monies to carry out a program of basic services to all types and categories of persons with disabilities. In order to provide these services, the NRA recommends the full funding of this entitlement provision ($972 million).

This is not an enormous amount by any stretch of the imagination. While we hear, and certainly share, common concerns regarding our Nation's economy, we must not allow our country to deprive our most disadvantaged population of the bare minimum of hope these modest funds can provide. In times of troubled economics, the handicapped persons of this Nation have for too long suffered and shouldered more than their share of the burden.

Mr. Chairman, this is not a new program. Indeed, it is not a Great Society nor even a New Deal program, but one that has been tried and proven for more than 60 years. It is one of the few successful Federal programs that you as a member of this body can point to with pride. It is one of the few programs which generally has not suffered from mismanagement, fraud and abuse, as exemplified by many of our latter day programs.

State governments have met the Federal challenge and have continued to overmatch in real dollars the Federal grants. More important, the Congress must realize that to fail to meet this modest level of funding will add to the welfare and institutionalized costs which are currently astronomical. For the most part, this burden will be borne by the Federal government.

Mr. Chairman, good economic sense dictates that this Subcommittee fully fund this provision of Federal law. Here, as in few areas which you must address in the overall appropriations process, the need is well documented and the return to the state and Federal treasurys well known.

The Basic State Vocational Rehabilitation Program provides formula grants to the various state rehabilitation services to handicapped youths and adults. The direct services program provides for a wide and total range of services and activities necessary to render a handicapped individual employable. Services may also be provided to families of handicapped persons when such services will contribute substantially to the rehabilitation of such individuals.

Mr. Chairman, with the passage of the 1973 Rehabilitation Act and subsequent amendments, increased emphasis has been given to providing services to those individuals with the most severe handicaps. The National Rehabilitation Association enthusiastically endorses this Congressional mandate, and the state rehabilitation agencies have been doing a credible job in carrying out this emphasis. In Fiscal Year 1980, the state agencies served approximately 1,350,000 disabled persons of which 45 percent are defined as having severe disabilities. Over 250,000 individuals were rehabilitated during FY 1980, including a high percent who were severely disabled.

Unfortunately, Mr. Chairman, all of these statistics represent a decrease in service to this vulnerable population. This is due, in part, to the new emphasis on serving first the severely handicapped and the lack of adequate resources. Indeed, the increased emphasis mandated by Congress on serving the severely disabled individuals has occurred without significant increases in the appropriations provided for the needed services. It is generally accepted that the overall increase in inflation in the U.S. has amounted to at least 13 percent during the past. However, the increase in appropriations for programs authorized by the Rehabilitation Act has amounted to considerably less than that.

It is generally recognized that it costs from 2 to 2-1/2 times more money to rehabilitate a severely disabled person compared with the costs of rehabilitating a non-severely disabled person. Therefore, the shift in emphasis to providing services to severely disabled persons with fewer actual dollars has necessitated an adjustment by the state rehabilitation agencies in that fewer persons are being served and fewer being successfully rehabilitated for the same amount of money. Added to this cost factor are the additional expenses created by such legislation mandates as the individualized written rehabilitation plan, family services, post-employment services, and annual reviews of ineligibility. Again, the increased demands on state rehabilitation agencies has come about without significant increases in appropriations.

The NRA recommends to the Subcommittee that Basic State Vocational Rehabilitation Services be funded in Fiscal Year 1981 at the full amount authorized, $972 million, with the full realization that this increase is still less than actually needed.

Mr. Chairman, the underpinnings of any successful program must be strong. I next speak specifically to the need for Research and Training.

NATIONAL INSTITUTE OF HANDICAPPED RESEARCH (Section 201(a)(1))

Mr. Chairman, Public Law 95-602 added a dramatic dimension to research for handicapped persons, adults and youth. I speak of the authority and new beginnings of the National Institute of Handicapped Research. We are, indeed, at a milestone, and therefore, feel that an appropriation of $40 million will provide a forward step in its second full year of operation, while continuing to support the on-going work of the Rehabilitation Research and Training Centers and other exemplary projects.

TRAINING (Section 304)

Mr. Chairman, the NRA truly believes that if the services to handicapped persons in our public and private agencies are to continue, there must be an adequate quality and quantity of well-educated and trained professionals. We are greatly concerned at the Administration's lack of understanding of the need for providing adequate resources for this area of endeavor. Indeed, a recission request of $5.1 million has been made which would reduce the meager FY 1981 appropriation to only $20.4 million. For without persons trained to serve well the severely handicapped population, it is necessary that we accept a lower quality of rehabilitation, and this, we pray, that this Administration and this Subcommittee does not want to do.

I would bring to the Subcommittee's attention the fact that it is the hope of the NRA that at least $30 million can be appropriated for rehabilitation professionals.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING (Section 731(a))

Last, but not least, Mr. Chairman, the NRA recommends $45 million be appropriated to carry out the provisions of the Act with respect to the Comprehensive Services for Independent Living Programs. This Program is designed to enable severely handicapped persons who may not be eligible for vocational rehabilitation services to live more independently with their families or in the community or to secure and maintain employment, if possible.

In addition to the continuation of the 75 projects funded in previous years, this amount will enable new starts and will allow coverage in all states.

The NRA believes that services must be provided for persons living in more rural areas and smaller states where the center concept may not be as adaptable as those now found in large urban areas. While the NRA supports such centers, the concept of comprehensive services is much broader and a beginning should be made to reflect the amendments provided through the law passed in 1978. Therefore, the NRA urges the Subcommittee to appropriate at least $ 45 million in FY 1982 in order to establish the Services Program in Title VII, as well as to continue the Grants Program.

Mr. Chairman, in closing, let me make several observations. **First**, let us not forget to distinguish between those programs that work and those that are questionable. Second, let us not forget that this program is one that reduces the Federal deficit, not increases it. Third, let us not forget that we are talking about human beings who often have no place to go for help in order to help themselves become productive citizens again if the Congress forsakes them. Fourth, today we are able to serve only 1 in 20 who need such services.

This population will not riot; nor, for the most part, will they demonstrate as did the mineworkers a few days ago. Nor for the most part will you hear from them by letter or other means.

They will not make demands.

But, Mr. Chairman, for those who have bothered to understand what this program is all about and what it means to handicapped persons, they have found this to be a balanced, comprehensive, and successful program. But most of all, it is an example of man's humanity toward each other.

The National Rehabilitation Association urges this Subcommittee to renew its commitment to our handicapped population who are looking to you for that support.

Thank you once again for giving us the opportunity to speak on behalf of persons with disabilities who need these services.

RECOMMENDATIONS FOR APPROPRIATIONS FOR REHABILITATION SERVICES FOR FISCAL YEAR 1982

(in millions)

ITEM	APPROPRIATIONS FY 1981	AUTHORIZATIONS FY 1982	RECOMMENDATIONS FY 1982
BASIC STATE REHABILITATION SERVICES			
Section 100(b)(1)	$845.75	$972.0	$972.0
Section 110(b)(2)	8.509		
COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING			
Section 731(a)	18.0	Such sums	45.0
NATIONAL INSTITUTE OF HANDICAPPED RESEARCH			
Section 201(a)(1)	35.0	100.0	40.0
REHABILITATION TRAINING			
Section 304(e)	25.5	50.0	30.0

STATEMENT OF DR. DONALD W. DEW

Mr. Chairman and members of the Subcommittee, my name is Dr. Donald W. Dew, President of the National Council on Rehabilitation Education (NCRE). I serve as Director of Training and Research Utilization of the Rehabilitation Research and Training Center and as Associate Research Professor of Medicine at The George Washington University in Washington, D.C. The National Council on Rehabilitation Education, which has a membership of 80 universities, represents hundreds of individuals who work in rehabilitation education and research. I appreciate the opportunity to testify before this Committee and submit our statement for the record.

IMPORTANCE OF REHABILITATION EDUCATION

Mr. Chairman, the first issue I would like to discuss is the importance of rehabilitation education to the provision of adequate rehabilitation services. Common sense tells us that rehabilitation personnel who provide needed services to disabled individuals need to be adequately trained prior to entering the profession. In addition to pre-service education, there is a need to provide a continuous effort in maintaining and upgrading the skills required to achieve rehabilitation goals that lead to economic independence for the severely disabled. As you are aware, the Rehabilitation Act of 1973 and its ammendments require that severely disabled citizens be provided quality rehabilitation services. Adequate provision of those necessary services is dependent upon well-trained rehabilitation personnel.

Congress has not only shown in the past their concern and support for effective rehabilitation services for the disabled, but has also recognized the need to provide for the training of rehabilitation personnel who deliver those services. Federal support for rehabilitation training, such as rehabilitation counselors, vocational evaluators, placement specialists, and paraprofessionals, is essential to the effective continuation and improvement of the rehabilitation services necessary to economic independence and self-sufficiency. Rehabilitation training has continued to enhance the competency level of rehabilitation staff across this nation.

NCRE MANPOWER STUDY

During the past year, NCRE has taken the initiative to conduct an in-depth survey related to rehabilitation education programs across this country. The study, which was accomplished through a NCRE committee chaired by Dr. Glen Geist from the Illinois Institute of Technology, was designed to help determine where graduates of RSA-supported as well as non-federally supported long term rehabilitation education programs were being employed. Dr. Geist's study indicated that of the 175 identified programs, 105, or 61%, reported data regarding 3,389 graduates. Out study showed that of these 3,000 plus graduates, 70.7% of the bachelors level trained personnel, approximately 90% of the masters level trained personnel, and approximately 97% of the doctorate trained - personnel remained in the field of rehabilitation. In other words, approximately 90% of those individuals who are trained by rehabilitation education programs remained in the field of rehabilitation. We consider this an outstanding record. A comprehensive needs assessment survey conducted by these same programs shows that the number of graduates each year are not keeping up with the need for personnel in the field of rehabilitation.

FUNDING LEVEL FOR REHABILITATION EDUCATION

The NCRE membership is aware of the difficult times which lie ahead for federally funded programs. During the past three years, we have seen inflation impact on rehabilitation education programs in addition to experiencing smaller appropriations for what we feel are vitally needed educational programs. It is our feeling that block grant awards to states would have a major negative impact on rehabilitation education programs. With consultation with our colleagues, many of whom are testifying today, such as the Council on State Administrators in Vocational Rehabilitation, the National Rehabilitation Association, and the National Association of Rehabilitation Research and Training Centers, NCRE is requesting support at the 30 million dollar level for Fiscal Year 1982.

SUMMARY

Mr. Chairman, as we look toward the future with the hopes of insuring that we have competent, professionally trained individuals who will deliver the many vital services needed by our nation's disabled, it is important that we plan now by training these individuals. Colleges and unversities do train individuals for the future, and, subsequently, must be able to retain qualified educators and researchers to deliver educational programs. NCRE is hopeful that this Committee will support our educational efforts for the future by supporting the needed appropriations for Fiscal Year 1982.

RECOMMENDATIONS FOR APPROPRIATIONS FOR REHABILITATION SERVICES FOR FISCAL YEAR 1982

(in millions)

ITEM	APPROPRIATIONS FY 1981	AUTHORIZATIONS FY 1982	RECOMMENDATIONS FY 1982
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Section 304(e)	25.5	50.0	30.0

JOINT STATEMENT OF GLEN O. GEIST AND BRIAN T. MCMAHON, ILLINOIS INSTITUTE OF TECHNOLOGY

Pre-service Rehabilitation Education: Where Graduates Are Employed

Introduction

State/federal vocational rehabilitation is a comprehensive program with several components. In addition to service delivery, the program includes aspects which impact on the provision of services such as research and training. Whereas the entire program is experiencing the crunch of reduced federal financial support, training and education appear to be most severely effected. From a high of $30.5 million appropriated in fiscal year 1979 for rehabilitation training, the current level stands at $25.5 million. This represents a 16% reduction in the wake of congressional authorizations which call for an increase to $45 million. And the Reagan administration promises even more drastic reductions.

Within rehabilitation traininq, in-service training and continuing education, both directed toward the already employed professional, seem to be holding their own in terms of dollar allocations whereas long-term or pre-service training is feeling the largest dimunition of fiscal resources. In light of this, the National Council on Rehabilitation Education conducted a study to gather information relevant to the continuing need for long-term rehabilitation education programs.

Method

One hundred seventy-five rehabilitation education programs were identified in the following service areas: Undergraduate Rehabilitation Services (45); Graduate Rehabilitation Counseling (88); Graduate Vocational Evaluation (8); Graduate Rehabilitation Facilities Administration (8); and Doctoral Rehabilitation Programs (25). Directors of all identified programs, whether funded or not by the Rehabilitation Services Administration (RSA), were sent a research packet including cover letter, directions and questionnaire in early September, 1980. A follow-up was sent to nonrespondents in mid-October. In addition, telephone calls were made to nonresponding program directors to further encourage data returns.

Two types of data were requested from program directors. First, they were asked to supply the investigators with any information they had gathered pertaining to the need for their respective programs, preferably from a needs assessment inventory. Second, they were asked to provide data concerning their graduates during the 1978-79 and 1979-80 academic years according to the categories listed in the first column of Table 1. The first four categories provide descriptive information. The following five categories are related to types of employment within the rehabilitation field. The first subgroup includes state vocational rehabilitation agencies which serve either general or blind populations. Next are private not-for-profit facilities which are directly or indirectly funded by the state-federal vocational rehabilitation program and primarily serve state agency clients such as rehabilitation centers, rehabilitation hospitals, and workshops. "Related Rehabilitation Work" encompasses private not-for-profit settings not funded by the state/federal program but which embody rehabilitation programs such as state psychiatric facilities, community mental health centers, and secondary educational institutions. "For-profit Rehabilitation" includes private sector companies with rehabilitation programs such as insurance companies, industries, and private consulting firms. "Rehabilitation Education" includes both education and research programs such as long-term and continuing education programs, research and training centers, and rehabilitation research institutes. The final four categories incorporate activities other than rehabilitation employment such as studying for an advanced degree in rehabilitation, working or studying in a field other than rehabilitation, being unemployed, or whereabouts unknown

Results

Of the 175 identified programs, 105 or 60% of the directors returned questionnaires in a usable form. With respect to each program service area, the percentage of usable returns was as follows: Undergraduate Rehabilitation Services (48%); Graduate Rehabilitation Counseling (68%); Graduate Vocational Evaluation (40%); Graduate Rehabilitation Facilities Administration (33%); and Doctoral Rehabilitation Programs (41%). Five universities, however, reported data for more than one service area program on a single questionnaire, contrary to the directions. Thus, data from 13 programs are not identifiable according to specific program service areas and therefore are described under the column entitled "Mixed" in Table 1. Nevertheless, the data from these 13 programs are useful for the overall picture and so are included under the "Total" column.

Placements of Graduates

Table 1 also summarizes the activities of pre-service rehabilitation education program graduates. There are 3389 graduates accounted for by the respondents for the two year period of interest. Both numbers and percentages for each response category per service area are provided.

By combining the five categories of rehabilitation employment with the advanced studies in rehabilitation grouping, we see that 84% of all graduates enter or remain in the profession. As one would expect, commitment to the field increases as the level of training increases, from 70% for bachelor level graduates to 96% for doctoral level graduates with the masters level graduates hovering around 90%. In addition, the data by and large support the position taken by RSA in the past few years that education programs should make a concerted effort to attract, train, and place in employment persons from minority groups as well as individuals who themselves are handicapped. Finally, the data suggest that most pre-service programs are training a large majority of female students.

Needs Assessment

Although almost one third of the respondents provided information pertaining to the question about program need, the data was received in a variety of formats and types such that neither comparing nor combining the data was possible. Six rehabilitation counseling programs that reported needs assessment survey data were selected, however, as examples of programs providing evidence of the need for rehabilitation counselors. Table 2 provides estimates of rehabilitation counselor positions vacancies based on the data provided by these six programs. Most programs surveyed agencies within the geographic area immediate to the program, although two contained data from surrounding states. Most noteworthy is a comparison of estimated vacancies with the average number of yearly graduates. It is obvious that vacancies far exceed the number of graduates available for employment.

Discussion

The obvious conclusion is that a high percentage of graduates of rehabilitation education programs enter employment within the field. This is true for all levels of education and specialty service areas. A significant proportion of these graduates enter employment with the state agency, especially those from rehabilitation counseling programs. This is somewhat surprising in light of recent studies alleging a negligible growth rate in state agencies. The largest group of graduates assume employment with facilities which primarily serve state agency clients. Considering these two employment areas together, it is clear that approximately half of all graduates work in jobs directly involved with the state-federal vocational rehabilitation program. Approximately another quarter of the graduates are in related jobs which entail indirect involvement with the state-federal program. These three major employment categories do show differences according to service area. Furthermore, relatively few graduates begin their careers in the private for-profit sector, despite its apparently rapid growth. The percentages reported in each of the employment areas undoubtedly reflect the respective service area mission and the field's demand for such manpower.

Few graduates are lost to employment in another field. Even the percentage of unemployed graduates is somewhat misleading since several respondents indicated that some students just graduated at the time of data collection and were actively seeking jobs in rehabilitation. Finally, it is likely that a significant portion of the "unknowns" are actually working in the field.

Overall, there is a high percentage of non-whites and handicapped persons entering the field through long-term training programs. Some service areas, however, could improve in this regard. The number of females entering the rehabilitation field no longer seems to be at issue. Indeed, one might be concerned about the relatively low number of males in the training programs. There certainly is room for improvement in administration and doctoral programs which show a lower percentage of females, but perhaps higher than might have been expected.

Among the service areas represented, rehabilitation counseling programs were the most attentive to the importance of the data requested. This is reflected in the high percentage of returns as well as the low percentage of "unknowns". Perhaps this can be attributed to the fact that these programs have become accustomed to accountability demands by state agencies and some regional RSA offices.

It is more difficult to draw conclusions from the needs assessment data due to the inconsistent formats used by responding program directors. This is compounded by the possibility that programs in relative proximity to each other may have obtained data from the same sources. Nevertheless, the six programs selected for inclusion here are relatively free of these problems and thereby give a reasonable estimate of actual need. Granted, the numbers are small compared to a national perspective, but the conception and findings deserve some attention. Specifically, these programs are not producing a sufficient number of graduates to meet the demand for positions within their respective geographic areas.

Accordingly, the most reasonable conclusion is that pre-service rehabilitation education programs continue to meet a need within the field, based on the employment of their graduates and results of their needs assessment surveys. To remain viable, the vocational rehabilitation program must continue to provide quality service for its clients. Quality is closely related with training, whether the training is of the in-service, continuing education, or pre-service variety. Each of these training components has its place in the state-federal vocational rehabilitation program. The apparent demand for well trained rehabilitationists is a clear signal for continued maintenance by the vocational rehabilitation program if a high quality service delivery system is to be sustained.

TABLE 1. PLACEMENTS OF REHABILITATION EDUCATION PROGRAM GRADUATES FOR ACADEMIC YEARS 1978-79 and 1979-80

	Number and Percentages (%) of Graduates Per Program Service Area						
		Graduate Masters Degree Programs					
	Undergrad. Rehab. Serv.	Rehab. Counseling	Vocational Evaluation	Facilities Administration	Doctoral	Mixed	Total
No. of Graduates	990	1912	85	152	29	221	3389
Non-white	146 (15)	330 (17)	3 (4)	11 (7)	2 (7)	39 (18)	531 (16)
Handicapped	67 (7)	301 (16)	8 (9)	13 (9)	3 (10)	24 (11)	416 (12)
Female	756 (76)	1171 (61)	45 (53)	43 (28)	11 (38)	94 (43)	2120 (63)
State VR Agency	68 (7)	428 (22)	9 (11)	42 (28)	1 (3)	29 (13)	577 (17)
Non-profit-Facilities	241 (24)	531 (28)	40 (47)	66 (43)	4 (14)	83 (38)	965 (29)
Related Rehab. Work	195 (20)	530 (28)	11 (13)	9 (6)	6 (21)	45 (20)	796 (24)
For-profit Rehab.	52 (5)	116 (6)	12 (14)	10 (7)	3 (10)	10 (5)	203 (6)
Rehab. Educ.	22 (2)	36 (2)	2 (2)	9 (6)	14 (48)	9 (4)	92 (3)
Student in Rehab.	122 (12)	33 (2)	0	3 (2)	0	10 (5)	168 (5)
Working or student in other field	68 (7)	50 (3)	0	0	0	5 (2)	123 (4)
Unemployed	34 (3)	73 (4)	0	1 (1)	1 (3)	4 (2)	113 (3)
Unknown	188 (19)	115 (6)	11 (13)	12 (8)	0	26 (12)	352 (10)

TABLE 2. NEEDS ASSESSMENT DATA FOR SIX REHABILITATION COUNSELING PROGRAMS

Program	Year of Survey	# of vacancies in Prior Year	Est. # of vacancies next yr.	next 5 years	Ave. # of Grads. Per yr.
SUNY-Albany	1979	--	59-64	207-264	19
Rhode Island College	1979	--	47-58	--	23
Mississippi State	1980	41	92	--	22
Univ. of Wisc.-Mil.	1979	70	--	220	25
Ill. Inst.-Tech.	1980	57	58	145-177	14
Seattle Univ.	1979	--	135	271	8

STATEMENT OF ANDREW S. HALPERN, REHABILITATION RESEARCH AND TRAINING CENTER IN MENTAL RETARDATION, UNIVERSITY OF OREGON

Introduction and Overview

The purpose of this testimony is to describe the merits of Rehabilitation Research and Training Center (RTC) Program and to make recommendations concerning its level of funding during Fiscal Years 1981 and 1982. At the present time, the RTC Program is administered within the National Institute on Handicapped Research (NIHR).

The RTC Program came into existence nearly two decades ago. Its original goals, as reported by the 1962 Congressional Appropriations Committees, were threefold:

--to provide a continuing mechanism for multidisciplinary research to discover new knowledge and methods in all aspects of the rehabilitation process.

--to provide training for professional and allied personnel who are committed to helping handicapped people achieve their maximum potential as well-functioning citizens.

--to assure the effective dissemination and utilization of research findings within our service delivery systems.

These three goals have remained constant over the years.

The RTC Program began in 1962 with the establishment of two centers. Today there are 22 centers located throughout the country. Each of these centers reflects a common set of features which comprise the conceptual foundations of the program.

Placement of the Centers Within Universities

Each RT Center is affiliated with a major university. Such affiliation provides the Centers with the resources that are necessary to conduct a strong program of research and training. These resources include access to students and faculty from a variety of disciplines, physical facilities for housing the Center, and, frequently, a service delivery component that provides rehabilitation services to handicapped citizens. Interestingly enough, in several instances the establishment of an RT Center has led to the subsequent development of a university department of physical medicine and rehabilitation where none formerly existed.

Long Range Mission

A commitment to programmatic and longitudinal research is a major hallmark of the RTC Program. This commitment requires that each Center identify a limited set of specific areas which constitute the focus of its efforts. Individual research projects are expected to relate to each other and to contribute cumulatively to a coherent body of knowledge for the resolution of practical problems that are faced by disabled people. Because of this long range programmatic mandate, RT Centers have been able to develop and nourish a "critical mass" of expertise that is essential if we are to conduct a truly effective program of rehabilitation research.

Geographic Decentralization

The 22 existing RT Centers are widely dispersed geographically. Each is guided by the influence of a regional advisory council. These councils consist primarily of representatives from rehabilitation service agencies and consumer groups who are the intended beneficieries of Center products and activities. This decentralization of the RT Center program provides a mechanism for keeping Center personnel in constant dialogue with a grass roots constituency while simultaneously focusing resources on problems that are national in scope.

Summary of Accomplishments

In November, 1977, a report was published by the Department of Health, Education and Welfare (HEW-105-76-4109) describing an objective evaluation of the RT Center Program conducted by ABT Associates, Inc. of Cambridge, Massachusettes. This report was extremely complimentary, and concluded with the following overall recommendation:

> "We conclude that the RT Center Program deserves continued and elevated support. This conclusion is based on four important observations:
>
> --The RT Center Program has a sound conceptual base.
> --The RT Center Program is exceptionally active.
> --The RT Center Program is an effective resource magnet.
> --The RT Center Program has supplied many noteworthy innovations to the field of rehabilitation."

The accomplishments of the RT Center program which led to this recommendation are even stronger today. The following list provides only examples of the proven areas of productivity and expertise that currently exist within the 22 RT Centers:

--Sexual functioning and bladder control for people with spinal cord injuries.
--Treatment of chronic pain.
--New technology for measuring residual heart stress tolerance after a heart attack.
--New technology for straightening spinal deformities.
--Vocational evaluation and training techniques for severely disabled people.
--Program evaluation systems for enhancing accountability and cost-effectiveness of service delivery programs.
--Biofeedback training to help stroke patients regain lost mobility.
--Evaluation and training techniques aimed toward the community adjustment of mentally retarded and emotionally handicapped people.
--Adapting personal computers for the communication needs of non-vocal people.

These and other areas of accomplishment have immediate practical impact upon the lives of disabled people.

Why the RT Center Program Should Be Maintained

The accomplishments of the RT Center Program are certainly powerful reasons in themselves for continuing to support this program. These accomplishments are largely the consequence of an enlightened organizational structure that blends effectively Federal, state, and local resources.

A Resource Magnet

As highlighted in the conclusions of the ABT report, the RT Centers consistently attract additional funds to supplement their basic Federal grants. During the timeframe of the ABT evaluation (1975-76), it was documented that for every dollar of Federal core-grant funds awarded, an additional 75 cents was generated from other sources, including private foundations, host university contributions, and fees for service. This not only multiplies the impact and cost-effectiveness of the Federal investment, but also testifies to the confidence of other funding sources to serve as a supplement to the basic Program.

Programmatic and Longitudinal Mandate

The organization of each Center's mission into long-range core areas of effort helps to assure that major problems can be addressed, and that the outcomes of research will be disseminated and utilized through product development and the training of service providers. It is only the prospect of long-range funding that has allowed each Center to gather and retain the concentration of human resources that is required to respond effectively to such a mandate.

The Cutting Edge

Many accomplishments of the RT Center Program are at the cutting edge of science and technology in a manner that has immediate application within service delivery programs for disabled people. Since it seems inevitable that funds for these service programs will decrease subtantially over the next several years, it is all the more important to use whatever dollars are available in the most effective and cost-efficient manner that is possible. RT Centers have provided and can continue to provide a significant response to this need.

Dangers of Block Grant Funding

As was previously indicated, RT Centers operate within a decentralized model, located in many universities throughout the country and guided by the influence of regional advisory councils. One might be tempted to infer that such a model is amenable to block grant funding through the separate states. In my opinion, such a funding mechanism is completely untenable, and would amount to a tacit decision to dismantle the program. There are two basic reasons for this opinion.

First, one must realize that each RT Center has regional and national constituencies in addition to those that reside within its home state. For example, our own Center in Oregon offers training to service providers in 12 western states, and the products of our research are disseminated and utilized nationally. Any attempt to negotiate funding agreements with a broad consortium of states would be administratively so complex that it would surely end in failure.

The second argument against block grant funding derives from the difficulties that each state is likely to encounter as it attempts to distribute block grant funds to a multitude of deserving social service programs, assuming that the block grant mechanism is ultimately adopted for Fiscal Year 1982 and beyond. With a general mandate to use such funds for direct services, and a greatly reduced overall budget, it would be difficult if not impossible politically for any state to use block grant funds to support research.

The survival of the RT Center Program depends entirely upon categorical support from the Federal Government. With such support, it can continue to secure supplemental funds from other sources.

Budget Recommendations

The RT Center Program is currently supported within the general appropriations that are designated for the National Institue on Handicapped Research (NIHR). Four other programs are also supported by NIHR: (1)

bioengineering centers; (2) research projects; (3) utilization and dissemination projects; and (4) international projects. My recommendations will pertain to the funding level of the RT Center Program within the NIHR appropriations.

Budget History

The rehabilitation research program budget in 1969 was $32 million. The value of $32 million in Fiscal Year 1969 dollars was approximately $50 million in Fiscal Year 1979. Actual appropriations during Fiscal Year 1979 and Fiscal Year 1980 were $31.5 million, and the current Fiscal Year 1981 appropriation, prior to President Reagan's recision request, is $35 million. During recent years, the RT Center Program has received approximately 50 percent of the total appropriations for rehabilitation research.

Although the accomplishments of the RT Center Program have been significant, as described above, the full potential of the program has been inhibited by fiscal constraints. Over the past decade, the funding of this program has remained constant in a range of $14 million to $16 million. In real dollars, this has amounted to a steady and unrelenting erosion of support.

Specific Recommendations

During Fiscal Year 1981, the RT Center Program should be supported at its original appropriation level of $16.775 million. This same level should be a minimum appropriation for Fiscal Year 1982. Any increment up to $18.45 million, a 10 percent increase, should be reserved for the expansion of existing centers, in order to begin moving these centers toward their proven capacity. Any increment above $18.45 million should be used to initiate the funding of new centers.

These decisions concerning RT Center Program support should be stipulated as earmarked funds within the overall NIHR appropriation.

STATEMENT OF MERLE ARNOLD

I am Merle Arnold, President of Hope Enterprises, Inc., in Williamsport, Pennsylvania. I am appearing before you today on behalf of the National Association of Rehabilitation Facilities to present NARF's recommendations for FY 1982 appropriations. I want to thank the subcommittee on behalf of the Association for this opportunity to testify.

NARF is a national organization of rehabilitation facilities with more than 700 institutional members. Members provide a range of comprehensive rehabilitation services to more than 300,000 handicapped people annually. These members include comprehensive rehabilitation hospitals, rehabilitation units of acute care hospitals, sheltered workshops, outpatient rehabilitation facilities and work activity centers.

Rehabilitation is the process by which an integrated program of services are provided to help a person, disabled by illness or injury, gain higher levels of function. Such services address vocational, medical and other needs. The goal of the rehabilitation process is to help people be self-supporting, by enabling them to engage in remunerative competitive employment and exist outside an institutional setting.

Community-based, non-profit rehabilitation facilities play a critical role in this process. There are now some 3,000 such facilities throughout the United States. In excess of 400,000 people are served annually in such programs. Rehabilitation facilities have expanded their focus beyond the traditional federal state vocational rehabilitation programs to meet the needs of these people. The programs affecting the delivery of services to handicapped people are:

Rehabilitation Act of 1973
Title XX, Social Services
Comprehensive Employment and Training Act
Mental Health Systems Act
Developmental Disabilities Act

Mr. Chairman, I wish to address these programs briefly and then discuss them within the context of the Administration's social services block grant proposal.

I. Rehabilitation Act of 1973

The Rehabilitation Act of 1973, as amended, embodies a comprehensive strategy to help handicapped people. The Act authorizes purchases of rehabilitation services, grants to test ways of delivering services to the handicapped, training of handicapped people and programs to build, equip, and modernize facilities. It also authorizes research on the special needs of handicapped people and authorizes special programs for those severely handicapped people through independent living centers. The Act is a proven success. The lifetime earnings of rehabilitatedn people has improved $10.80 for every $1 spent.

While the Act has created a comprehensive program of services for the handicapped and a comprehensive set of programs to construct, equip, staff and train facilities to deliver such services, funding under the Act has not supported this concept. Because of inadequate funds, the Act is not comprehensive in its application. The January FY 1982 budget proposed to continue this trend. The revised budget would remove major parts of this strategy by proposing not only to restructure the programs under a consolidated block grant, but by reducing funding by 25%.

Mr. Chairman, we do not support a 25% reduction in funding from FY 1981 levels. Instead we would propose that each program -- each building block -- authorized by the Act be funded at minimally adequate levels outlined in Exhibit I attached so that the comprehensive rehabilitation strategy of the Act can be implemented. We particularly urge that funds be made available for the state grant program, Projects With Industry program, the Facilities Improvement Grant Program and facilities construction grants.

Under the state grant program over 243,000 people were rehabilitated in FY 1980. States are prepared to provide the required matching funds. In fact in 1979, states over-matched the federal funds by $28 million. The January budget proposed funding at $900 million; the revised budget would fund it at 75% of FY 1981 or $640 million and fold it into a block grant. NARF supports the full authorization of $972 million.

The Projects With Industry Program (PWI) authorizes contracts or jointly financed cooperative agreements with employers and organizations for projects designed to prepare handicapped individuals for gainful employment. PWI increases the chances for placement due to exposing the client to a real work environment that lessens the trauma of changing from a client to an employee. The program has a high-75%-and successful placement rate. Each person placed and retained in competitive employment may no longer be dependent on the rehabilitation program for services or other public assistance programs such as Title XX, SSI or CETA, for services and income. given its proven success, it should be expanded to $10 million in FY 1982.

The FIG program is intended to provide seed money to establish new service capability through program development and purchase of equipment. FIG grants provide assistance to improve and expand vocational training services, production activities, evaluation services, social and work adjustment services and sheltered employment. According to a report by American Indian Consultants, Inc., regional offices and state facility specialists strongly support the program and feel that it is effective in providing better quality services to clients. The program should be funded at the FY 79 level of $7.5 million.

II. Title XX, Social Services

Title XX provides funds to finance an approved program of social services directed toward five goals to help the poor, elderly, disabled and others obtain and maintain their independence. Funds are automatically distributed to the states. States have been using about 30% of these funds to purchase services from private providers including rehabilitation facilities. NARF recommends that the program be continued at the FY 82 entitlement level of $3.1 billion.

III. Comprehensive Employment and Training Act

CETA provides funds to cities, counties and states to provide employment and training services for the economically disadvantaged, including the handicapped. The majority of the program is administered at the state or local level. There is also a national program administered by the Secretary of the Department of Labor. The 1978 amendments to CETA recognize the employment and training needs of the handicapped and the role rehabilitation facilities can play in meeting these needs. In 1979 181,680 handicapped people benefited from CETA services.

Title II of CETA authorizes the major employment and training services programs. These include, for example, work experience, assessment, on-the-job training, evaluation, job placement and counseling. They offer handicapped people an opportunity to receive the services and training needed to move into competitive employment. The person may not be eligible for the vocational rehabilitation program or may have completed a vocational rehabilitation program and needs the additional CETA training to obtain unsubsidized private employment.

Title III of CETA authorizes national programs which help the special needs of targeted populations facing severe unemployment problems. For example, the On-The-Job-Training project is available to facilities across the country as a result of a national contract between NARF and the Department of Labor. The purpose is to develop and promote training programs in rehabilitation facilities for subsequent hiring of the handicapped. This program is of critical importance in helping these people obtain employment skills and employment. This is particularly true during a period of severe economic upset. The January FY '82 budget request for Title II is $4.587 billion; for Title III $560,678 million (national programs), and for Title VII, Private Sector Initiative $329 million. The revised budget of March 10 proposes to phase out Public Service Employment under Title II-D and VI, consolidate Title II B, and C, and reduce funding for Special National programs by $108 million or 50% and maintain Title VII as proposed in the January budget. NARF recommends that whether or not consolidated programs under Title II, Parts B and C should be funded at $300 more than recommended in the January budget NARF also supports the $325 million for the Title VII initiative. However, we strongly object to any cuts in Title III Special National programs and recommend that it not be reduced $1 million, but instead be increased from the January budget figure of $150 million to $200 million.

IV. Mental Health Systems Act

Individuals suffering from mental illness represent one of the more poorly served sections of the disabled population. From a NARF survey conducted in 1977, 44% (34,121) of people served by 159 reporting facilities were mentally ill. The DOL Sheltered Workshop Study showed that from 1973 to 1976 the number of mentally ill in workshops increased 41%. Unfortunately, existing state and community mental health programs have not been focused upon serving these people in a deinstitutionalized setting. The mentally ill need greater programmatic support in order to live in the most unrestricted and independent manner. Support for continued state deinstitutionalization, community mental health centers, training of mental health personnel, and provision of mental health services in other settings are needed as a part of the total programs available to the handicapped.

The Mental Health Systems Act, signed into law in October, 1980, addresses these needs. For FY 1982, $339 million was requested in the January budget. In FY 1981 $324 million was available. NARF recommends that the Committee support the January FY '82 budget recommendation for an increase of $15 million for a total of $339 million whether or not funded through block grants.

V. Developmental Disabilities Services Facilities and Construction Act

The Development Disabilities Services program was initially developed to serve more than two million persons with developmental disabilities in the United States. Persons with developmental disabilities often require specialized lifelong services to be provided by many agencies in a coordinated manner in order to meet the person's needs. The Developmental Disabilities program has traditionally focused on deinstitutionalization services and alternative services in the community. In addition to direct services, protection and advocacy of individuals, the Developmental Disabilities program provides for a University Affiliated Facilities program to provide research and training for personnel and practitioners providing services to the developmentally disabled. The FY '81 appropriations history, FY'82 January budget request and revision and NARF recommended FY'82 appropriations are in Exhibit I.

VI. Block Grant Proposal

The balance of my statement addresses the Administration's proposed social services block grant proposal that would encompass most of the programs mentioned above. I must make it clear that NARF, in conjunction with other members of the Coalition Concerned about Developmental Disabilities, firmly believes that the programs authorized under the Rehabilitation Act and other programs serving the handicapped are successful in meeting the objective of restoring or maintaining people at their maximum functioning level; that consolidation is only a mechanism for funding; that the same level of budget authority should be continued despite the form; and that the success of these programs - and the future potential of handicapped people - should not be compromised because of a desire to use a change in form as a foil for reducing funding.

The consolidation proposal proposes to include programs authorized by Title XX of the Social Security Act and by the Rehabilitation Act of 1973, as amended, plus other programs to be funded in FY '82 at 75 percent of the aggregate funding for such programs in FY 1981 or approximately $724 million under the Rehabilitation Act (using a base of $965 million) and $2.2 billion under Title XX alone.

The asserted justification of the Administration's proposal is that aggregation of these disparate programs with elimination of most, if not all, current federal requirements will permit savings in administrative cost and other program efficiencies sufficient to offset the reduction in funds available.

NARF-member facilities would be directly affected by this proposal, if it is adopted. As noted above, in addition to programs fostered under the Rehabilitation Act, rehabilitation facilities provide support services, employment and various types of therapies for many mentally retarded and mentally ill people. Many such clients have returned to their communities programs for delivery and financing of social services (which was initiated because of inadequate state efforts in the first place) while at the same time drastically reducing funding is a prescription for disaster. First there would be a chaotic situation within state governments as unrelated agencies jockey for position. This turmoil would absorb more, rather than less, administrative effort and money. Finally, many programs developed by rehabilitation facilities and other institutions would be strangled by withdrawal of funding, inadequate rates of payment or both.

Accordingly, we can give qualified support to a realignment and consolidation of social services programs, but cannot support a corollary reduction in funding.

We would suggest to the Subcommittee that in its consideration of this matter it focus on several key principles, as follows:

1. Continue total funding at least at current levels while eliminating duplication and mismanagement to result in more service delivery. See Exhibit I attached for a breakdown under the Rehabilitation Act and under the consolidation proposal.

2. Limit administrative costs which states may charge to any block grant program.

3. Require an overall state plan with public participation in its development, as per the present Title XX system.

4. Require minimum set-asides for certain targeted populations, at perhaps 90% of consolidated funding levels, with 10% subject to state discretion.

5. Allow funding for modernization, rehabilitation and construction of rehabilitation facilities.

6. Require purchase of service from existing providers to avoid duplication of capital facilities.

7. Require maintenance of effort by states in affected program areas included in the block grant program.

8. Continue research, demonstration programs, evaluation, technical assistance and similar functions through a federal entity.

We commend this set of specifications to the Subcommittee and again reiterate that there is no way that a consolidated program can be implemented with the sharp cutbacks proposed without chaos resulting and a totally negative impact on the successful programs serving handicapped people. Realignment of social services delivery would be an intricate and complex task for any state. To try to achieve such a thing in the face of these deep budget cuts would be an irrational and destructive process.

I would be pleased to answer any questions Mr. Chairman.

EXHIBIT I

PROGRAMS AIDING THE HANDICAPPED
FY 82 BUDGET REQUEST
($ in millions)

Program	FY 81 continuing 2] resolution	FY 82 January Budget Request	FY 82 Revised Budget Request	NARF FY 82 Recommendation
REHABILITATION ACT[1]				
Total	969.460	1015	734[1]	1158
State grants	854.3	900	640	972
Innovation and Expansion Grants	0	0	0	11.8
Independent Living				
Part A	0	0	0	25
Part B	18	21	13.5	25
Part C	0	0	0	2.5
Part D	0	0	0	2.5
PWI	5.5	5.5	4.12	10
Business Opportunities	1	2	.75	1
Comprehensive rehabilitation centers	2	2	1.75	3
Service Projects	28.160	24.360	18.270	24.360
FIG	0	0		7.5
Training	25.5	25.5	19.1	28.5
National Institute on Handicapped Research	35	35	35	35
Facilities Construction	0	0	0	10

PROGRAMS AIDING THE HANDICAPPED
FY 82 BUDGET REQUEST
($ in millions)

Program	FY 81 continuing resolution	FY 81 January Budget Request	FY 82 Revised Budget Request	NARF FY 82 Recommendation
MENTAL HEALTH COMMUNITY AND STATE GRANTS	324	339	260[3]	339
DEVELOPMENTAL DISABILITIES	61.18	61.18	39[1]	91
TITLE XX	2900	3100	2100[1]	3100
CETA				
Title II, B-C		1873	1873	2100
Title III (special national programs)	92	150	1	200
Title VII		324	325	325
SOCIAL SERVICES BLOCK GRANT (TOTAL FOR Title XX, Rehabilitation, D.D. Est.)	3930	4176	2873	4319

[1] Figures reflect proposed 25% reduction from the FY 81 level.

[2] Available through June 5, 1981.

[3] Figure reflects a proposed 20% reduction from the FY 81 levels.

STATEMENT OF JOSEPH L. COHEN

As will be demonstrated throughout the body of this testimony United Cerebral Palsy Associations, Inc. maintains a keen interest in a number of federal programs including P.L. 94-142, the "Education for All Handicapped Children Act", Vocational Rehabilitation, Independent Living, and Developmental Disabilities. All of these programs are so-called "categorical" programs which we believe continue to serve many unmet needs of handicapped children and adults. President Reagan's America's New Beginning: A Program for Economic Recovery calls for a wholesale and indiscriminate consolidation of federal social programs. Though the plan, if enacted, might save the federal government money in the short run, it does not address either the fiscal impact on state and local government nor the impact on the lives of persons with disabilities whose quality of life depends on these benefits and services.

We are fully cognizant of the fact that our nation is facing an economic crisis. However in considering the Administration's proposals we request the Committee to ask the following questions before endorsing such categorical consolidations:

(1) To what extent are federal resource allocation goals likely to be sacrificed if federal categorical programs are replaced?

(2) Without categorical objectives, will state and local officials be able to withstand pressures for tax reductions, debt retirement, and unwarranted subsidies to local interests?

(3) Will professionals and consumers lose visability, program influence, and program quality?

(4) Will consolidation or integration ameliorate the administrative problems and intergovernmental conflicts inherent in the categorical system?

(5) Do human service administrators possess sufficient knowledge in systems operations to truly integrate services?

In recent years, disabled Americans have begun to reach their full human potential at least in part through the assistance of the categorical programs listed above. Thus we respectfully urge the Committee and indeed, the Congress to carefully consider the questions which we have raised before making any changes in programs which directly effect the lives of disabled persons.

THE DEVELOPMENTAL DISABILITES ACT

State Grant Program

The Developmental Disabilities State Grant Program provided funds for coordinated and comprehensive services to persons who are developmentally disabled. Persons with developmental disabilities are often institutionalized, isolated and/or intellectually or severely physically impaired and thus require a number of services. The Developmental Disabilities State Grant Program provides an excellent example of a program which cross-cuts other federal and State programs and provides a mechanism where services can be accesses for the developmentally disabled individual. Through the State Planning Council, State government officials, providers of services and consumers themselves, can engage in meaningful dialogue concerning how funds can best be spent on behalf of this population. These discussions often result in enhanced services and increased dollars for the persons with developmental disabilities.

Perhaps the description given by Ms. Jane Chapin, Executive Director of UCP of Illinois of what her affiliate has done with the DD program funds will give the Committee some insight into what this program is doing for persons with cerebral palsy, and other developmental disabilities.

I am writing to confirm that in Illinois, our programs and consumers have indeed benefited by the federal DD legislation.

Our own agency has been the recipient of three statewide planning grants: "Specialized Needs of Persons With Cerebral Palsy," "Moving Ahead Community Living Alternatives for Persons With Developmental Disabilities" and a "Planning Study to Develop a Statewide Wheelchair Adaption Program."

> We are years ahead in our efforts to provide appropriate services for our clients, thanks to these DD Council grants. Currently, under a service grant, we are establishing in three locations across the state, wheelchair adaption centers which eventually will be supported by generic agencies referring clients to these centers. Thus hundreds, potentially thousands, of wheelchair clients will with proper positioning lead a more comfortable, healthier life."

UCPA joins with the Consortium Concerned with the Developmentally Disabled in recommending that the Developmentally Disability State Grant Program receive $49.8 million for FY 1982. The increase will be used to extend services to additional categories of disabilities covered under the Act, to implement the comprehensive evaluation system of services and manpower, and to allow states to develop programs which will cover their responsibilities for the four priority service areas mandated in the Act.

Protection and Advocacy

Perhaps one of the most important components of the Developmental Disability program is the establishment of Protection and Advocacy systems within each State and Territory in the United States. P&A systems are designed to provide personal and systematic advocacy to persons who are developmentally disabled. As pointed out earlier in this section, these persons have been institutionalized, isolated and/or are severely physically or intellectually impaired that such assistance is critical.

The recently published report, Protection and Advocacy in the United States - The First Three Years authored by R. Lee Henney, Ph.D., a leader in the field of developmental disabilities makes this statement about Protection and Advocacy Programs:

> "The Protection and Advocacy activity in most States is no longer an experience but truly a service which is well received and dynamically involved in the inter-relationship of service delivery to individuals at the local and State level. The evidence within the report demonstrates unequivocally that Protection and Advocacy has developed a character by which individuals, organizations, and service providers are brought together for the betterment of individuals with developmental disabilities. The Protection and Advocacy Program, in cooperation with the other elements, and in some cases single handily has allowed thousands of individuals who are developmentally disabled to live in a less restrictive environment, to secure an appropriate education, and to enjoy to the limits of their physical and mental capabilities activities within society that they had not heretofore realized prior to the development of the Protection and Advocacys activity within their State."

Dr. Henney also points out in another report entitled, The Impact of the Amendment of the Definition of "Developmentally Disabled" on the DD Program In FY '79 and FY '80, that of the cases handled by Protection and Advocacy systems across the country, only a few actually culminate in litigation, he states,

> "The fact that only 2 percent of all the cases handled by Protection and Advocacy agencies in the first three years required court intervention is an indication that society, programs, and individuals are able to work cooperatively to meet the needs of individuals who are developmentally disabled. The fact that very few of the cases required court opinion speaks well of society's desire to provide adequate programming and services for individuals that are developmentally disabled."

We fully agree with Dr. Henney's statement that advocacy has become an "inter-relationship of service delivery to individuals at the local and State level." It is not a coincidence then, that at least 31 UCP affiliates have full time advocacy programs and that many of these programs interface with their State P&A programs. Such advocacy efforts, working together on behalf of persons with developmental disabilities, have had dramatic effects upon human lives. To illustrate the human factor which is involved in such advocacy efforts, here is an example of what UCP of Santa Clara and San Mateo Counties did for one young woman. The affiliate was made aware of a 33 year old woman with cerebral palsy who was living with her parents and who had no activities outside of the home. Her parents tried to secure services for her, but because they were not knowledgeable about programs which serve disabled persons, they accepted the fact that their daughter would simply remain at home. Through the efforts of our affiliate, this young woman was evaluated by a local workshop program and is now in a vocational rehabilitation training program. She is working toward the goal of gainful employment.

Previous appropriations for this program have only allowed states to initiate limited activities and serve a limited portion of each states population. An increase in this program will allow Protection and Advocacy programs to move toward state wide representation for handicapped individuals in an area in which they are extremely underserved. For this reason, UCPA joins with the Consortium Concerned with the Developmentally Disabled in recommending that the Protection and Advocacy program receive $15 million for FY '82.

VOCATIONAL REHABILITATION

Basic State Grants

The State/Federal vocational rehabilitation program is supported by public funds and serves handicapped persons who can benefit from such rehabilitation services. Monies received from RSA are matched at the State level at a 80%/20% matching ratio. Services rendered by the State vocational rehabilitation agency are aimed at enabling the handicapped person to reach his or her vocational potential. It must be noted that State vocational rehabilitation agencies have a legislated responsibility to work in concert with private non-profit agencies in providing such services as independent living.

The Committee will be hearing from the Council of State Administrators of Vocational Rehabilitation, and because of their expertise in this area, we believe they are best qualified to speak to the needs of this program. However, we would like to briefly share some of our experiences with the vocational rehabilitation program and how it has served persons with cerebral palsy.

In the near future, UCPA will be entering into a Cooperative Agreement with the Rehabilitation Services Administration, the National Institute on Handicapped Research, and the Council of State Administrators of Vocational Rehabilitation. The primary purpose of the Agreement is to improve the rehabilitation services which are rendered to persons with cerebral palsy. Persons with cerebral palsy have a variety of handicapping conditions ranging from those with minor speech and/or ambulation impairments to severely impaired persons who may need special assistance simply to communicate.

Because of the multiple nature of these severe disabilities, they are frequently not a priority population to be served by the vocational rehabilitation system. However, we believe that the Cooperative Agreement will act as a catalyst to insuring that the needed services are rendered to persons with cerebral palsy. Some of the responsibilities which RSA has agreed to include the following:

- Encourage increases in the number of persons with cerebral palsy who are rehabilitated.
- Direct regional offices to assist States in the development of interagency agreements with UCPA affiliates.
- Provide consultation to State and local rehabilitation agencies in the provision of services to persons with cerebral palsy.

The lack of resources in the past has meant that persons with cerebral palsy, and others with severe disabilities, have not been sufficiently served by this system. There is a strong need to continue this program with additional monies in order for this population to receive these much needed services. Therefore, UCPA joins with the Council of State Administrators of Vocational Rehabilitation in recommending that the Basic State Grant program for vocational rehabilitation receive $972 million for FY '82.

Independent Living

P.L. 95-602 established a new title of the Rehabilitation Act, Title VII, entitled "Comprehensive Services For Independent Living" to provide independent living services to meet the needs of individuals "whose disabilities are so severe that they do not presently have the potential for employment but may benefit from Vocactional Rehabilitation services which will enable them to live and function independently." Eligible persons are those "whose ability to engage or continue in employment, or whose ability to function independently in his family or community, is so limited by the severity of his disability that vocational or comprehensive rehabilitation services are appreciably more costly and of appreciable greater duration" than VR services are required. Priority is given to persons now unserved by the Vocational Rehabilitation Programs.

When this program was enacted, many disabled persons across the country believed that this would be the federal program which would enable them to live with dignity and independence in their own communities. Now, three years later, citizens with disabilities are still awaiting this independence. The FY 1981 appropriations for this legislation is $18 million. This $18 million is restricted to Part B Centers for Independent Living. As yet there have been no monies appropriated for Part A, Services for Independent Living, which will allow States to provide much needed services. And yet, unless these services are provided to persons with disabilities, they will continue to be dependent burdens on our society rather than independent taxpayers. We fully realize that during these inflationary times it is not popular to advocate for a new human service program, but we believe that the cost of not implementing this program is far higher.

UCP of Pittsburgh has run an independent living program since 1975. This program serves, through a variety of community living arrangements, person who are severely physically impaired but are mentally alert. This program has enabled over 100 severely handicapped persons in the Pittsburgh area to achieve independence. Francis S. Hoist President of the Board of Directors of UCP of Pittsburgh makes this statement about the need for independent living:

> "Although many of the persons whom we have identified are severely disabled and require varying degrees of attendant care in the areas of feeding, dressing, bathing, bathrooming, etc., they are not sick individuals and they do not require skilled nursing care. Unfortunately, many of these folks are either already in or run the risk of eventually being placed in such institutions as John J. Kane Hospital, nursing homes, or a variety of other Intermediate Care Facilities for the Developmentally Disabled (ICF-DD's) that are designed to provide skilled medical care under stringent Medicaid regulations (Title XIX) that cost the taxpayers between $100 and $200 per day "patient." Although some of the clientele of our organization admittedly may require such treatment, it is believed that many of these precious tax dollars can be spent much more efficiently and more humanly by providing the disabled person the necessary resources to have "Control over one's own life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities..." as described in the accepted definition of independent living."

We join with the Consortium Concerned with the Developmentally Disabled and many other groups representing the disabled in recommending that this program be funded at $45 million for FY '82. This will allow for; 1) a reasonable initiation for the Part A, Comprehensive Services State Grant Program; 2) a continuation of Part B, Centers for Independent Living; and 3) a start-up for Part C, Independent Living Services for Older Blind Individuals.

The National Institute on Handicapped Research

P.L. 95-602 established the National Institute of Handicapped Research (NIHR) to develop a comprehensive, coordinated approach to the administration and conduct of research, demonstration projects, and related activities including training. Such a thorough approach is to include dissemination of information, financial support for the distribution of technological devices and equipment, and an increase in scientific and technological information. In addition to extending federal support for both the Rehabilitation Engineering Centers (REC) and Rehabilitation Research And Training (R&T) Centers, P.L. 95-602 earmarked a number of new research efforts, including joint projects with other federal agencies, a study of the special concerns of rural areas, special needs of persons 60 years of age and older, and support of model training centers to evaluate and develop employment potential.

We will not attempt to address all of the programs which are administered by NIHR but rather focus upon the potential effects which this Institute can have upon the lives of persons with cerebral palsy. As mentioned earlier, UCPA is about to enter into a Cooperative Agreement with RSA, NIHR and CSAVR. We are enthusiastic about this Agreement and we believe that its implementation will significantly enhance the lives of persons with cerebral palsy. Some of the tasks which NIHR has agreed to include the following:

- Encourage research into rehabilitation engineering specifically geared to meeting the needs of persons with cerebral palsy and promote the dissemination of such information.
- Include persons with cerebral palsy when preparing statistical reports and studies on employment health income, and other demographic characteristics of Handicapped people.
- Consider the needs of persons with cerebral palsy when conducting the newly mandated research programs concerning the use of existing telecommunications programs; the development of innovative methods of providing services for handicapped children; and the attraction and retention of rehabilitation professionals in rural areas.

It is our understanding that NIHR intends to place a greater emphasis on research related to the employment of severely handicapped persons in the future. UCPA would applaud such an increased effort in the area of employment because this is a critical problem for severely disabled persons. To this end we would like to see a greater number of Rehabilitation Engineering Centers (REC's) which are concerned solely with engineering needs of disabled persons in the work setting. Currently out of 15 REC's in the nation only one - our own Center Industries, Corporation affiliated with UCP of Kansas - is oriented to researching the employment needs of the disabled. We must add that we in no way wish to discredit the research which is being done by the medical REC's for clearly they are making an important contribution to the rehabilitation community. We simply wish to highlight the unmet employment needs of severely handicapped persons and we would be pleased to provide the Committee with further information if they so desire.

United Cerebral Palsy Associations, Inc. joins with National Rehabilitation Association and others in recommending that NIHR be funded at $40 million for FY '82. This will allow for a minimum amount of growth in the area of research for handicapped individuals.

P.L. 94-142 The "Education for All Handicapped Children Act"

State Grant Program

The implementation of P.L. 94-142, the "Education for All Handicapped Children Act" remains of paramount concern the United Cerebral Palsy Associations, Inc. Prior to the enactment of this legislation, children with cerebral palsy were either unserved of underserved by the public education system. In fact, prior to the enactment of P.L. 94-142, many UCP affiliates provided educational services to these children. Now that children with cerebral palsy have begun to be served by the public school system, many of our affiliates are closing these educational programs and beginning to look at other unmet needs of the handicapped community. Some of our affiliates continue to work in concert with their State and local education agencies to assure that these children receive the educational services which they will need in order to reach their full human potential. All persons concerned with this law - both parents and professionals - agree that a great deal of progress has been made toward meeting the goals of P.L. 94-142. Clearly, while much progress has been made much remains to be accomplished. UCPA believes all of the components of the law including such provisions as related services, an individualized education plan, due process procedure, and the least restrictive environment work together to insure that the handicapped child's individual needs are met.

While a complete discussion of these provisions is beyond the scope of this testimony, UCPA would be pleased to provide the Committee with indepth materials on these matters. Of particular concern to our organization is the provision of related services. Because children with cerebral palsy are often multiply handicapped, they may require one or more related services. Thus our organization has done some initial thinking on the provision of related services and other issues related to the implementation of P.L. 94-142, and would be pleased to share this information.

In considering appropriations for this legislation it is important to note that the authors of P.L. 94-142 were not simply responding to the pressures of "special interest groups" when this law was written. They were addressing the unmet needs of handicapped children. In some cases, parents of handicapped children had to turn to the courts in order to receive educational services for their children. Perhaps this quote from Hairston V. Drosick will illustrate the thinking of the courts:

> "A child's chance in this society is through the educational process. A major goal of the educational process is the socialization process that takes place in the regular classroom, with the resulting capability to interact in a social way with one's peers. It is therefore imperative that every child receive an education with his or her peers insofar as it is at all possible. This conclusion is further enforced by the critical importance of education in this society." (1)

It is our understanding that the Senate Committee on Labor and Human Resources as recommended to the Senate Budget Committee that the State Grant Program under P.L. 94-142 be funded at $1.14 billion for FY '82. We believe, that this is the minimum amount which the Congress should consider appropriating for this program.

Preschool Incentive Grants

The provision of preschool services to children with cerebral palsy is of critical importance. It has long been understood that the earlier a child with cerebral palsy receives early intervention and treatment the more functional that child will be later in life. In fact, many UCP affiliates provide preschool services on an ongoing basis. Yet it is clear that preschool services are still sadly lacking in many areas. This is supported by data from the Office of Special Education and Rehabilitation Services which indicates that, on the average the States are serving only 2.6 percent of the population between the ages of 3 to 5. We fully believe that, if children with cerebral palsy, and other developmental disabilities are to receive the maximum educational benefits, these services must begin with preschool programming.

The Senate Committee on Labor and Human Resources recommended to the Senate Budget Committee that this program receive $30 million. Given the data cited above from the Office of Special Education and Rehabilitation Services, we feel that this is the minimum amount the Congress should consider.

REFERENCES

Legal Challenges in Educating Handicapped Children, by Reed Martin, Research Press, 1979.

VOCATIONAL AND ADULT EDUCATION

Senator BURDICK. Our next panel will be on the vocational and adult education.

Introduce yourself and proceed as you wish.

Mr. BOTTOMS. I am Gene Bottoms, executive director of the National Association for American Vocational Association.

Dr. TAYLOR. I am Bob Taylor, executive director of the National Research Center, Ohio State University.

Mrs. GOLDSMITH. Joanne Goldsmith, of the National Committee Education Association.

Mr. EYRE. Gary Eyre, on the National Advisory Council on Educational Committee.

Ms. TURNER. Mary Turner, representing Dr. James Dorland.

STATEMENT OF GENE BOTTOMS, EXECUTIVE DIRECTOR, AMERICAN VOCATIONAL ASSOCIATION

Mr. BOTTOMS. I will make a very brief statement for American Vocational Association.

We ask Congress to reject the proposal for fiscal years 1981-82 and I would like to make three or four points in support of that recommendation.

We surveyed some 30 States and 25 of those States state that they are facing cutbacks at the State and local level in terms of real investment in this field.

So the notion that State and local can pick up these is a myth.

The second item of support that I would note that the State and locals cannot pick up, in 1972 Federal investments in vocational education real dollars, was—were dollars held constant for 1967, was $400 million.

In January of this year, the January appropriation has the purchasing power of $300 million. This has not been one of the great growths. Its growth has declined by $1 million.

Today the latest figures we have available per enrollment is that the per-people investment is $15 and back then it was $13.

The President is talking about the 1970 safety net.

For this bill to have the same level of Federal investment that it had in 1972, would take a $300 million increase.

Now, the arguments made at State and local to pick that up was that—and there is an error in one of my tables and I would like to correct it.

The total investment in 1972 averaged $151, if you hold the dollar for 1967 and in 1979, State and local investment still averaged $151, while Federal investment dropped, State and local investments remained constant.

So, in summary, the impact of this proposed cut will further cause deterioration in quality and cutbacks in programs across this Nation at a time when we need skilled workers.

I just refer to the Washington Post, that 80 percent of the jobs referred to by the President, in 33½ pages, require skilled people.

STATEMENT OF DR. ROBERT E. TAYLOR, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR RESEARCH IN VOCATIONAL EDUCATION

Dr. TAYLOR. I would like to highlight my testimony on support of programs of national significance, which are a very significant part, but a relatively small part of the vocational education appropriation.

This $10 billion catalyzes $5.6 billion of Federal, State, and local funds. It assures quality, relevance, and impact to the vocational programs.

And it has contributed materially to accelerating program improvement, nationwide, assisting States and localities in developing and improving appropriate high-quality programs.

If we are to achieve our goal of revitalizing our economy and improving our productivity and providing the kind of support that is needed to our national defense efforts, instrumentalities such as the National Center for Vocational Education, the National and State Occupational Information and Coordinating Committees and other activities funded out of this $10 million appropriation are going to be essential.

The National Center at the Ohio State University does more than conduct research. It is mandated by the Congress to provide leadership training.

Last year, we served over 2,000 State and local leaders in workshops and seminars conducted in 32 different States.

We have reached out and touched every State during the past year. We also provide information to the Congress for planning and policy, provide information to improve the valuation of services and planning and vocational education and contribute materially to dissemination and utilization of research and develop projects.

I might highlight our current emphasis in economic development which relates to the reindustrialization of America and the implications for vocational education.

We are working with the State director of vocational education to provide a national training effort—later this spring—in that area and recently released materials on entrepreneurial training to help vocational students be self-employed.

I would like to say this relatively small appropriation does influence the character, quality, and impacts of vocational investment, Federal, State, and local.

We can document impact on individual students and individual programs.

I appreciate very much your listening.

Senator BURDICK. Thank you for your very concise statement.

STATEMENT OF JOANNE GOLDSMITH, LEGISLATIVE CHAIRPERSON, NATIONAL COMMUNITY EDUCATION ASSOCIATION

Mrs. GOLDSMITH. I don't usually need a mike, but today I have laryngitis.

I appreciate the opportunity to be here this afternoon on behalf of the National Community Education Association.

I am accompanied by the executive director, Dr. Paul Turner. We only point out that we are facing, ourself, a cut of 69 percent of educational funding.

We had in the continuing resolution some $10 million appropriated. We are now back to $3.138 million, and we find that to be a disappointment because we feel and have hope that our programs do exactly what we would like to see in the new economy.

Community education is involved with people in the new community providing services across the board. Senior citizen programs, adult education, we work in many States, doing cooperative efforts helping to solve problems between agencies at the State level, those in health, those in recreation, those in parks, those who do planning, our aged population all find services in the community school.

We know that this money is well-spent. We know that it is effective and we find it surprising to face this kind of cut because we feel this program does, in effect, benefit all of our people, and we would urge you to take a good look at the community and program and keep schools open to provide services to the community and people, exactly where they live, there is lots in the testimony I would ask you to read it.

I thank you for your time.

Senator BURDICK. You did pretty well with that voice. [Laughter.]

STATEMENT OF GARY A. EYRE, EXECUTIVE DIRECTOR, NATIONAL ADVISORY COUNCIL ON ADULT EDUCATION

Mr. EYRE. I am very pleased that you are chairing this hearing today because it is your State that will be sponsoring a major adult education conference in Fargo the first part of April, where issues and concerns associated with adult learning will be addressed.

Council's testimony is quite explicit on the recommended appropriation levels for both fiscal years 1981–82.

The rationale is quite clear in the statement and can further be documented with your staff on the committee.

I wish to address some data about North Dakota and some other States. The 15 members of this committee represent 14 States, just this committee. And in those States, there are 10,975,000 American adults, 25 years of age and older, who have less than the completion of secondary school.

That is an average of 46 percent of that adult population. With less than a high school diploma. The competency is commensurate with that.

There is evidence that there are 5 million adults in this committee's 14 States, 5 million adults that have competencies, educational competencies of less than a sixth grade level of education.

That 5 million is equal to the entire population of the State of Missouri.

The Adult Education Act addresses that population and that Adult Education Act, in the course of the last 15 years, has a very enviable record in doing so.

Our advisory council's appropriation request is $122.6 million. And that is a State and local community-based organization for us and that effort is to address the problems of America's illiteracy and the illiteracy in the adult population.

I commend you for holding these hearings and particularly allowing adult education to represent our concerns. For over 53 million adults in this Nation, who do not have the completion of secondary education.

Thank you, Senator.

Senator BURDICK. How did this all happen?

Mr. EYRE. A multitude of things that have happened in the education system. Individuals perhaps graduating from our secondary programs are dropping out of school without competencies, adults needing retooling and retraining for economic revitalization of this Nation.

The figure is dropping, thank heavens, due to the efforts of State education agencies and local school districts and community-based organizations.

But it is very difficult, Senator Burdick, to put a single finger on the cause.

We know what the effect is and we are trying to alleviate that situation vis-a-vis this program.

Senator BURDICK. Thank you.

STATEMENT OF MARY TURNER, NATIONAL ASSOCIATION FOR PUBLIC CONTINUING AND ADULT EDUCATION

Ms. TURNER. Senator Burdick, thank you very much for allowing me to testify on behalf of Dr. Dorland.

I will be very brief because he has already submitted a statement and I will simply hit the highlights.

To date, the economic benefits from the Adult Education Acts have been countless in the millions and millions of dollars in savings resulting from people being removed from public assistance, from earnings for people who became employable through adult education.

I would like to point out that all of the accomplishments of the act have been that the cost is less than $2 per instructional hour. We feel that this is a most cost-effective program.

Therefore, we recommend level funding for the Adult Education Act in fiscal 1981 for expenditures in fiscal 1982 at the same $122.6 million figure under which the program is currently operating.

This would involve no increase in expenditures, which have already been approved.

Our recommendation for fiscal 1982, for expenditure in fiscal 1983, is for the Adult Education Act to be funded at the same $122.6 million figure which it is receiving this year.

In effect, this would result in 3 consecutive years at that same level, which would be in keeping with holding the line on expenditures and making very good use of existing resources.

In connection, I wish to say we are requesting the maximum level of funding available for the truly needy adults who are the potential recipients of adult education.

I can assure you that adult educators will continue to be prudent stewards of whatever funds are made available to them.

We have tried to be both responsible and pragmatic in our funding requests.

Thank you for receiving this statement.

Senator BURDICK. Thank you, and I thank all of the panel.

[The statements follow:]

STATEMENT OF DR. GENE BOTTOMS

I am Gene Bottoms, Executive Director of the American Vocational Association (AVA). AVA is the professional association representing teachers and administrators of vocational education programs across the nation.

Thank you for providing us the opportunity to discuss with you the funding needs of public vocational education programs, which currently serve more than eighteen million Americans. We wish to present our case for maintaining vocational education funding at its current FY 81 level.

We are keenly aware of the fiscal pressures which our nation is facing. We believe that vocational education, like other federal programs, must be willing to reexamine how it is using its resources, work to eliminate costly duplication and search for new partnership efforts to solve national employment-related problems. Yet we feel that there are some key ways the federal government can aid us in assuring that our nation has the strongest possible employment training program. It is a program that is needed more desperately than ever in these tough economic times.

In the revised FY 82 budget sent to Congress this week, the administration is calling for rescissions of 25 percent in vocational education funding for FY 81 and for a 20 percent reduction in funding for FY 82 compared with the $784 million funding level provided in the FY 81 continuing resolution.

These cuts, if implemented by Congress will simply serve to intensify many of the economic difficulties that we are trying to solve.

I would like to build our case today for level funding for vocational education on the fact that vocational education offers the most cost efficient and effective means for building and renewing America's greatest resource: its human capital.

PROPOSED CUTS BASED ON INACCURATE INFORMATION

The proposed cuts in federal funding for vocational education are based on inaccurate information about its current financial picture. Vocational education did not, in the seventies, experience the financial growth that many other educational programs had. In fact, vocational education entered the eighties severely underfunded as a result of inflation, rapidly increasing enrollments and a declining federal investment throughout the seventies.

States and Local Communities Can't Make up the Difference

In their proposal to Congress, administration budget planners make no note of these problems and assume in their rationale for cutting vocational education that states and local governments, which are now providing ten dollars for every one federal dollar, can make up for the effect of the federal cuts. Both past history and the current financial positions of many of our states and local communities say otherwise.

States and local communities are, in many instances, no less strapped than the federal government. Many are reeling under the effects of Proposition 13 type legislation, from the effects of foreign competition on their major industries and from a declining industrial base.

In a survey of 30 states conducted by AVA last month 25 states reported that on top of federal cuts they expect losses in state and local funding of approximately $150-200 million within the next year.

Many states will do what Illinois has indicated it will do--trim their own budgets in accordance with the directions set at the federal level. Governor James Thompson has said "Some programs are so important we would try to make it up with state source money, possibly cutting some other state programs to provide the money. Others, we might say that if it is not that important to the federal government, it is not that important to us."

Thompson puts vocational education in the latter category.

In Oregon, which is experiencing an extremely severe economic downturn, state funding cuts are already planned which will directly reduce vocational education funds. In Portland combined state and federal cuts will force the closing of all auto mechanics, industrial mechanics and other lab courses. If they can't win approval of a local bond issue educational leaders say they will no longer have a viable program.

The states providing information to AVA report that at least 85,000 programs serving more than 3 million students will be affected in some ways. Some will be closed. Others will not be able to serve as many students as in the past. New programs designed to meet marketplace demands for more highly skilled workers cannot be started.

The slide in federal per student support for vocational education is not just beginning. In constant dollars, federal expenditures for vocational education have been declining since 1972 when federal funds provided $32 for every student. By 1979, the federal government was spending only $15 per student enrolled.

Following the administration's logic, state dollars would have compensated for the decline. The facts show otherwise. In 1972, states and local communities were providing $151 per student. In 1979 that figure was still at $151 per student. Therefore, when federal, state and local dollars per student are combined, there is a net loss of $17 per student--exactly the amount of the drop in federal dollars.

And these alarming statistics were amassed during a period when federal and state appropriations--in real dollars--were rising each year.

Enrollments of Disadvantaged Students Are Underestimated

The administration has said that there will be little impact on poor people if vocational education is cut because only about 15 percent of our students can be classified as disadvantaged. The National Center for Education Statistics figures that the administration cites cannot be used to make that case because they are not figures showing disadvantaged enrollments. They are figures showing the number of vocational students who can be served through setaside funds currently provided for serving disadvantaged students as part of the basic state grant. These funds are by no means adequate to serve all disadvantaged students who are currently enrolled in vocational education.

The Congressional Budget Office has estimated that at least 25 percent of all vocational education students can be classified as disadvantaged. An analysis of data contained in the NCES National Longitudinal Survey of the Class of 1972 suggests that the figures are even higher. Data from that study showed that more than one-third of all students of low and/or average socioeconomic origin and scholastic ability were enrolled in twelfth grade vocational programs. When vocational students were categorized on the basis of scholastic ability alone, 50 percent of them had a low academic ability.

Thus, vocational education is, to a great extent, a compensatory program for the poor and for students whose abilities are in areas other than academics. To cut vocational education support will therefore hurt most severely those who are most in need of vocational training to succeed.

Proposed Cuts Will Not Return Vocational Education to the Early Seventies

President Reagan says that his new economic plan will simply return many federally funded programs to the "safety net" position they held in the early seventies. If we are to return vocational education to the position it held in the early seventies, we must consider--not a cut--but an increase in funding. We would need a billion dollars to bring vocational educational funding back to the 1972 appropriations level in constant dollars. To bring appropriations per student back to the 1972 level, we would have to double the amount of the current million appropriation.

PROPOSED CUTS MAKE NO SENSE FOR THE ECONOMIC RECOVERY OF OUR NATION

The Administration recognizes that it must give high priority to activities that will contribute to the economic recovery of our nation. It has announced plans to provide incentives to industry to expand. Yet there seems to be an important link missing in the recovery program. Little mention is made of the formation of human capital to construct and run the plants, operate and maintain the new ma machines and implement the new technology.

Increasingly we see statistics that drive home the fact that America has a severe skills shortage. The President himself provided some statistics this week that attest to this fact. He reported that he had found 33½ pages of want ads in the Sunday, March 15 Washington Post. Yet he made an incorrect observation based on this finding. He seems to think that people have the skills needed but prefer unemployment to getting out and trying for available jobs. We submit that this is not the propoer conclusion. Yes, the want ads are hefty. Jobs are available. But they aren't being filled because the people seeking employment do not have the skills to qualify for these jobs.

We have done our own analysis of the Washington Post ads. At least 1,900 of the advertised jobs require some kind of specialized preparation. Of this group, approximately 80 percent require vocational skill training. Can we continue to ignore this mismatch between the needs of the marketplace and the skills of our citizens?

Consider these other facts which also address the skills shortage:

° A recent analysis by the Council for Northeast Economic Action of 11 key Massachusetts manufacturing industries concluded that the average age of the current labor force was 51.5 years. Yet Massachusetts is experiencing an enormous acceleration in business capital formation which is requiring a large number of skilled technical workers for now and the long-range future.

° The Associated General Contractors of America reports that apprentices are not being trained fast enough to replace retiring journeymen in the commercial construction trades -- an industry which accounts for three out of every ten skilled workers in America.

° The Defense Science Board Task Force has concluded that a continuing shortage of skilled labor is a major factor in the spiraling costs and increased lead time required to complete defense contracts.

Vocational education can be the key element in a new national employment and training policy which deals head on with developing people for the hard-to-fill jobs that are critical to a rejuvenated economy. At the same time, it can help raise our nation's productive capacity with its unique ability to instill in its students a sense of individual responsibility and pride in work.

OF THE CUTS ON LOCAL PROGRAMS

At the state and local level, the proposed budget cuts will have three immediate and devastating types of effects:

1. Quality

Many of our vocational programs are already feeling serious effects of a decade of declining support. They have not been able to keep in tune with the needs of the workplace. In vocational education, to a greater extent than in any other area of education, equipment and instructional expertise must be updated regularly or they become outmoded and of no use to the people or the industries they are supposed to serve. Yet our nation's productivity hinges to a great extent on the ability of our workforce to produce goods and services more efficiently. Vocational education programs can prepare workers to fuel this growth if they are not allowed to deteriorate.

2. Disadvantaged/Handicapped

Twenty-seven of the 30 states responding to the AVA survey reported that one of the most profound effects of the cuts would be a reduction of the extra services needed to help disadvantaged and handicapped students succeed. Five thousand programs serving 370,000 students would be affected.

As an example, Michigan reports that 135 programs which now serve 10,742 disadvantaged students could serve only 6,445 if the cuts become a reality. Programs for handicapped students which now serve 4,571 handicapped students could only serve 2,743.

3. Economic Recovery

States and local communities depend to a great extent on federal support to fund economic recovery activities. This funding supports programs which train workers for new and expanding industries and for hard-to-fill technical jobs, upgrade existing workers in new technology and retrain displaced workers for new jobs. The industry/education partnership has become increasingly significant to most states' economy.

A statement from New York pinpoints the impact of federal reductions on economic development activities:

> "This reduction would devastate our most significant efforts in retraining and upgrading underemployed and unemployed adults. Ninety percent of all apprenticeship programs depend on VEA [Vocational Education Act] funding for a major portion of the related instruction component support. Without a comprehensive apprenticeship program this state cannot begin to meet industry's need for a trained workforce."

Michigan reports that without economic development funds there will be little possibility for vocational education to have an impact on alleviating the acute economic situation in that state. They will have to abandon plans to allocate $4.5 billion for on-going vocational programs in economically depressed areas.

VOCATIONAL EDUCATION--AN INVESTMENT IN ECONOMIC RECOVERY

Vocational education is a wise investment--one which has been the choice of states and local communities for decades. They have been willing to spend their dollars in a partnership effort with the federal government because the partnership allows for grassroots accountability and control. Other federal programs that have been designed to provide training assistance in conjunction with jobs programs have been less successful because they have not become a part of the on-going educational structure.

Such 100 percent federally-funded job training programs in reality place most of their emphasis on providing enrollees with temporary jobs without giving them adequate training to move into permanent jobs in the private sector. During FY 80 only $800 million of all Comprehensive Employment and Training Act (CETA) funds went for classroom training including participant stipends.

However, there is a way to make these federally-funded programs more efficient. In cases where CETA has entered into training agreements with vocational education, available training funds are being used effectively to move people into jobs. In the Oklahoma Governor's Balance of State Prime Sponsorship program summary reports for FY 78 through FY 80, statistics show that although costs for vocational training were the lowest per client of any of the types of training used, the students served had the highest success rate--ranging from 68 percent to 75 percent depending on the program--in finding jobs.

I ask you to think about what might have happened over the past decade if Congress had maintained its share of the vocational education partnership and in fact put more dollars into this on-going program. Would we face the same paradox today of large numbers of jobs available accompanied by high levels of unemployment? And, would the government have saved money in the final analysis?

The formation of human capital must be a vital component of our economic recovery program. Building the strength of vocational education is vital to that effort. If we reduce the financial investment at this time, our nation's ability to produce skilled workers will decline substantially. We ask that, instead of reducing this support, you take a closer look at how this nation's programs of vocational education can be a model for a cost-effective partnership among state, local and federal governments. This type of flexible model, supported by both employers and taxpayers, should be the base upon which we build our vocational education and training system for the 80's.

IMPACT OF CUTS IN FEDERAL SUPPORT ON STATES

(Taken from 30 states' responses to a survey in February)

Nature of Impact	Extent of Impact		
	# of States	# of Programs	# of Students
1. Reduction of Quality or Elimination of Programs	ALL STATES	85,000	3 million
2. Obsolete and Defective Equipment - Not Replaced	ALL STATES		
3. Cuts in State/Local Funding	25		
4. Reduced Services to Disadvantaged	27	3,000	280,000
5. Reduced Services to Handicapped	27	2,000	90,000
6. Reduced Efforts in Economic Revitalization	22	3,300	640,000
7. Reduced Services in Depressed Areas	24	3,000 (Adults)	330,00 (Adults)
		5,000 (secondary & postsecondary)	1,300,000 (secondary & postsecondary)

HELP WANTED: March 15, 1981 - Washington Post

PROFESSIONAL

Management 67

Engineers 101

CLERICAL (Technical)

Legal Secretary 26

Secretary 311

Typists 49

Word Processing 57

Clerical (Skilled)

Receptionists 109

Clerical 48

TECHNICAL (Skilled)

Mechanics 31

Printing/Press 31

Automechanics 29

Electricians/Electronic Technicians 31

Technicians 8

HEALTH

Medical Ass't/Technician/etc. 78

Nurses LPN/RN 145

Physical Therapist 30

Respiratory Therapist 9

Dental Ass't/Hygienist 59

COMPUTER

Programmers 70

Keypunch 25

Computer Operators 75

Data Entry/Processing 30

ACCOUNTING

Bank Tellers 22

Bookkeepers 69

Accountants 68

SERVICE

Waiters and Other Hotel Workers 67

Cooks 21

Maintenance-Mechanics Engineers, Ass't 38

Design/Draftsmen 28

Typesetters 16

Teachers and Aides 32

OTHERS

Bricklayers 1

Carpenters and Helpers 12

Construction Workers 1

Real Estate 43

Retail 36

Sales 181

Sheet Metal Mechanic/Helpers 4

FEDERAL APPROPRIATIONS FOR VOCATIONAL EDUCATION

YEAR	Consumer Price Index	Actual Dollars (inflated) in thousands	Real (Constant) Dollars in thousands
1972	125.3	495,988	395,840
1981 (as of January 1981)	260.5	784,041	300,975

Vocational Education would require $1,031,163,000 in actual dollars to bring appropriations back to the 1972 level.

EXPENDITURES FOR VOCATIONAL EDUCATION AND PER PUPIL COST
(in constant dollars)

YEAR	Enrollments	Federal Expenditures (constant dollars)	Total Expenditures (constant dollars)	Per Pupil (Fed. Exp.)	Per Pupil (State & Local)
1972	11,602,144	371,931,221	2,123,510,501	32.05	151.00
1979	18,201,700	270,021,815	3,021,960,994	14.84	151.00

Table 3

Expenditures for and Participants Receiving Classroom Training under Selected CETA Programs, October 1978 through September 1979, U.S. Totals

Program	Classroom training	
	Expenditures	Participants
Title II		
Parts A,B,C,		
Prime Sponsors	$ 611,669,861	427,733
Voc. ed. set-asides	86,490,943	n.a.
Linkages set-aside	467,065	n.a.
Part D	13,404,524	14,496
Title III		
Part A	5,169,954	7,921
Title IV		
Part A	56,116,348	48,884
Parts B,C	17,592,059	41,644
Title VI	5,582,383	8,035

Source: U.S. Department of Labor, Employment and Training Administration.

SOURCE: Technical Analysis Report Series, Report #4. Manpower-Education Coordination: Two Decades of Frustration by William H. Wilken and Lawrence L. Brown III - January 1981.

"During fiscal 1980, CETA outlays on classroom training including participant stipends are about $800 million (see Table 3)."

Estimated Percentage Distribution of In-School Expenditures by Function Under the CETA Title IV Youth Employment and Training Program, October 1978 through September 1979, U.S. Total and Selected States.

		Percent of in-school funds expended on:					
State	Total	Administration	Allowances	Wages and benefits	Worksite supervision	training	Services
U.S.	100.0	10.0	4.6	56.6	1.1	7.3	20.5

Planned Percentage Distribution of In-School Expenditures by Function Under the CETA Title IV Youth Employment and Training Program (YETP), October 1978 through September 1979, U.S. Total and Selected Cities

		Percent of in-school funds expended on:					
State	Total	Administration	Allowances	Wages and benefits	Worksite super vision	Training	Services
U.S.	100.0	7.2	4.7	58.5	1.1	7.7	20.8

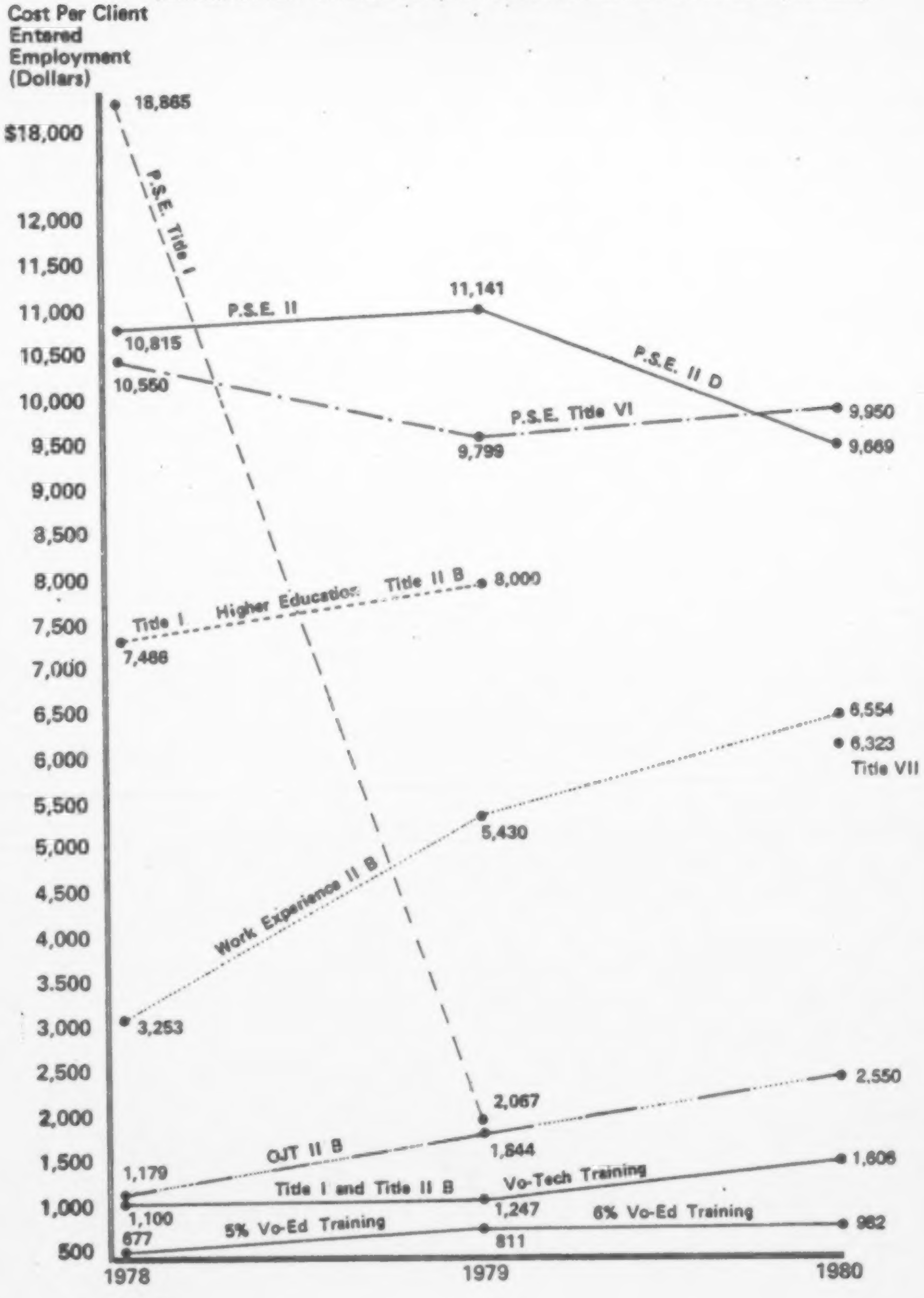
SOURCE: Technical Analysis Report Series, Report #4. Manpower-Education Coordination: Two Decades of Frustration by William H. Wilken and Lawrence L. Brown III - January 1981, pages 30 and 31.

CETA

OKLAHOMA GOVERNOR'S BALANCE OF STATE PRIME SPONSORSHIP PROGRAM SUMMARIES, FY 1978-79-80

Cost Per Client Entered Employment

(Statistics From Oklahoma Department of Economic & Community Affairs)



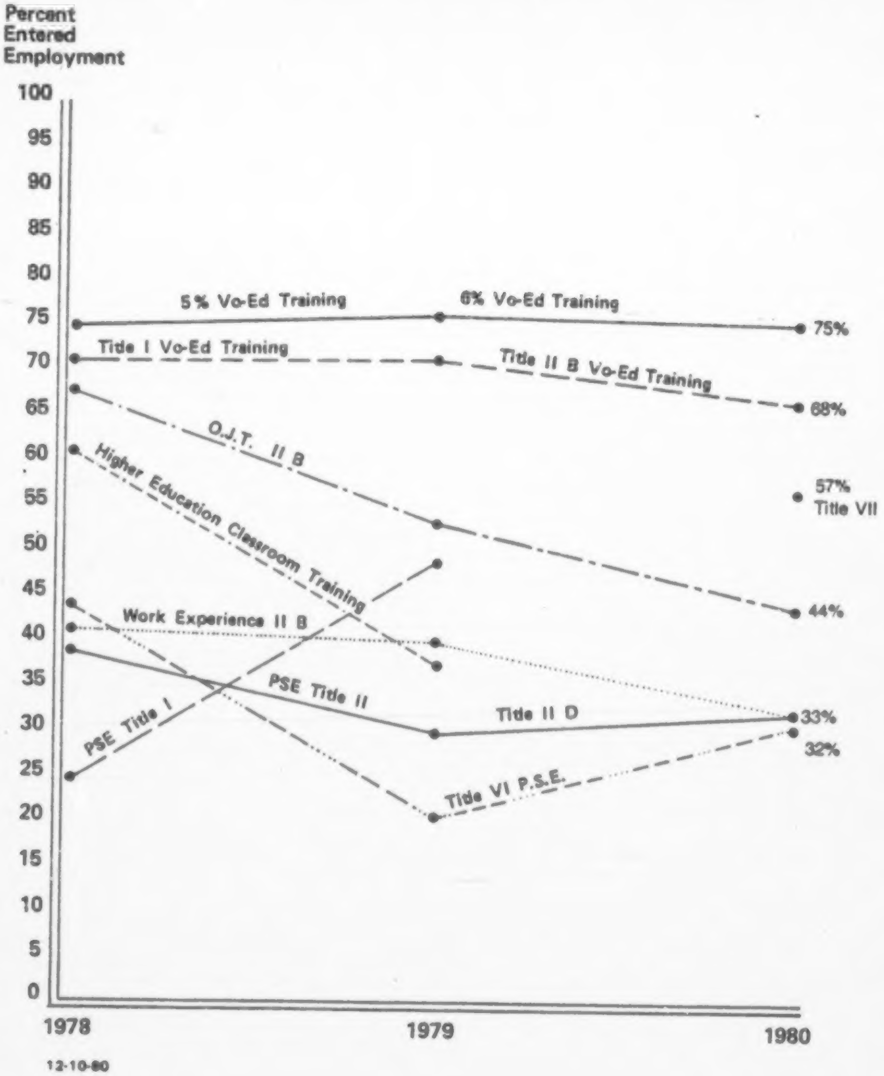
12-10-80

CETA

OKLAHOMA GOVERNOR'S BALANCE OF STATE PRIME SPONSORSHIP PROGRAM SUMMARIES, FY 1978-79-80

Percentage of Clients Entered Employment

(Statistics From Oklahoma Department of Economic & Community Affairs)



IMPACT OF CUTS IN FEDERAL SUPPORT TO SEVEN STATES

A. Impact on Quality of Programs:

- Defective and obsolete equipment and machinery will not be replaced. (Hawaii)
- Cutting funding dollars would drastically impact on each community's effort to prepare persons for private sector employment. (New York)
- Equipment replacement would be dropped; guidance and teacher education would disappear; curriculum development would be reduced in each occupational area. (Ohio)
- 1,000 programs would not have the benefit of modern, up-to-date instructional equipment. (Michigan)
- Teacher education (pre- and in-service) programs conducted by state-supported colleges would be eliminated, thus stopping the production of qualified teachers to meet replacement and new program needs in the state. (South Carolina)
- Elimination of highly needed activities such as equipment upgrading, upgrading, curriculum development to meet changing needs, and professional development. (Wisconsin)
- Cutbacks in federal vocational funds will seriously compound the impact on local vocational education; quality which has been eroding with the purchasing power of federal funds available to Oregon will deteriorate at a more rapid rate; inability to update equipment (60% of federal fund expenditures at the local level); without continued federal support, the quality of existing programs will decrease and the capacity of institutions to provide needed new programs will be lessened. (Oregon)
- Curriculum development, dissemination, and infusion efforts would cease. (South Carolina)

B. Impact on the Disadvantaged and Handicapped:

- At the postsecondary and adult levels, the statewide programs for disadvantaged and handicapped persons will be cut back;
- At the secondary level, support services for the disadvantaged and handicapped will be curtailed. (Hawaii)
- Support services for disadvantaged and handicapped students would be lost, and probably many of the programs would be dropped. (Ohio)
- We are presently matching disadvantaged and handicapped Section 102(a) Federal set-asides at the state level, and therefore, local school districts have no matching requirements. However, approximately $2 million in state/local funds are still being expended by local districts for these programs. If federal funds were reduced it is uncertain whether these state/local funds would be shifted to support regular vocational programs currently under Subpart 2. If this shift occurred, it would significantly reduce services to disadvantaged and handicapped persons. (South Carolina)
- Probable discontinuance of services to the disadvantaged and handicapped. (Wisconsin)

C. Impact on Economic Revitalization

- All adult upgrading courses and some apprenticeship classes will be eliminated; all short-term in-service and upgrading courses will be eliminated; services will be drastically affected in economically depressed areas. (Hawaii)

- Without federal funds for economic development, there would be little or no opportunity for education to have an impact in Michigan, which is currently faced with one of the most acute economic situations that has existed since the 1930 depression.

- Reduction in specific projects for business and industry liaison, fostering economic development. (Wisconsin)

- Oregon is on the threshold of integrating directly economic development and growth and vocational education. High technology industry, natural gas discoveries and immediate plans for coal mining on the southern Oregon coast are examples pointing to the need for specialized programs. Immediate plans for funding four programs for new industry projected for the next two years will be cancelled.

- We are working very closely with other state agencies and economic developers to attract and expand industries in New York State. Current negotiations will have a direct impact on 3,610 jobs involving firms from outside New York State seeking to relocate here or national companies planning extensive expansions of present facilities. In addition, there are short-term training projects aimed at saving jobs in industries affected by technological change and for companies faced with extensive retraining and upgrading needs that are beyond their financial capability. The lack of VEA funds will in all likelihood change the location and expansion plans of many of these companies and force up to discontinue this vital activity.

- Plans to allocate $4,500,000 for ongoing vocational programs in economically depressed areas would have to be eliminated. (Michigan)

D. Impact on Access:

- All VEA-funded secondary and adult programs for the general population will be affected; in some areas of New York State, agencies would eliminate adult training, causing more adults to apply for public assistance.

- Appresticeship-related instruction would be impaired, and cooperative and work-study programs reduced; large cuts would occur in Associate degree programs; displaced homemakers programs would be eliminated along with sex equity programming; placement services and day care service dropped. (Ohio)

- Adult short-term vocational education training would be reduced and displaced homemaker programs would be eliminated; would eliminate all energy education programs at postsecondary institutions. (South Carolina)

- Estimated loss of 29 programs in depressed areas, affecting 4,400 persons. (Wisconsin)

STATEMENT OF DR. ROBERT E. TAYLOR

I would like to thank the Chairman and members of the committee for this opportunity to testify on behalf of vocational education in general, and more specifically on Programs of National Significance, which constitute the national program improvement capacity for this important enterprise. I am aware of the tremendous problems confronting this committee. You face difficult choices between competing programs and rethinking the federal role in a number of important program areas. I am sure you are aware of the cumulative effects of inflation over several years of level funding in this category and the consequences it has on our ability to fulfill our mission.

In my view there is no more appropriate role for the federal government than that of investing in national program improvement--those activities which influence the quality, character, relevance, and impact of not only federal appropriations, but state and local investments as well. I am talking about a $10 million appropriation to lever and catalyze a $5.6 billion dollar enterprise. National program improvement activities have been an essential and effective part of the vocational education legislation since 1963. We have established major components to facilitate and accelerate program improvement nationwide and to assist the states and localities in developing and providing appropriate programs. During the past year progress has been made in expanding and improving opportunities for career oriented vocational training to those who need, it including those who need it most such as the disadvantaged, handicapped, postsecondary students and adults, and in moving towards sex fair enrollments. Additionally major steps have been made to posture vocational education to optimally contribute to economic revitalization.

The vocational education enterprise is a decentralized system which has in its history repeatedly proven that it can be responsive to both local and national priorities. It is accessible to most of our population and employers and possesses a high commitment to preparing and upgrading a skilled workforce. If we are to achieve our national goal of revitalizing the economy, more productive and increasingly skilled workers will be essential. The National Center for Research in Vocational Education possesses a special capacity to enhance the efficiency and effectiveness of the present system of technical and vocational education. As our nation expands its national defense capacity, American industry and skilled workers will be faced with updating their technology and improving their productivity. The extent to which the vocational education system, the National Center and other critical elements funded under Programs of National Significance are allowed to be productive partners with other instrumentalities in society is limited primarily by available human and fiscal resources.

The National Center for Research in Vocational Education

In authorizing the National Center for Research in Vocational Education, the Congress specified several interdependent functions. They are: 1) conducting applied research and development; 2) providing information for national planning and policy; 3) providing leadership development through an Advanced Study Center and an inservice program such as the National Academy; 4) disseminating the results of research and development; 5) acting as a clearinghouse for information on state research, exemplary and innovative projects, curriculum development, and on contracts made by the Secretary pursuant to Section 171; and 6) to work with states; local agencies, and other public agencies to develop improved methods for evaluating vocational programs.

During the past year the National Center has had outreach activities and participation with every state in the nation and many local communities. Vocational education has become more responsive by utilizing improved planning and evaluation procedures. We have accelerated broader adoption and use of research and development, provided leadership development to thousands of state and local leaders, contributed essential information for national planning and policy, and provided critical services to foster state and national program improvement activities.

APPLIED RESEARCH AND DEVELOPMENT

R&D has focused on increasing the responsiveness of vocational education. New emphasis has been placed on activities contributing to economic development and revitalization, in addition to ongoing work in planning, sex fairness and improved programming for special populations.

In January, the National Center co-sponsored a research planning conference at the National Academy of Science to examine the full range of implications of reindustrialization and its ultimate impact on human resource development programs, such as vocational education. We have undertaken the technology transfer effort which will investigate processes by which new technologies are created, adopted, and applied in business and industry. New roles, methods, and strategies for postsecondary vocational education institutions will be identified to enhance their responsiveness and capacity to facilitate technological adaptation as a means for improving productivity, economic growth, and industrial revitalization. Projected findings will focus especially on technical education and its changing responsibilities to its students, to industry and business, and to the communities of which it is a part, with implications for curriculum changes and new institutional linkages.

We have just released 20 instructional guides for entrepreneurship training through postsecondary programs. Our current emphasis in planning is on improving the match between vocational programs and labor market demands with particular attention on areas of skill shortages.

Ten states were assisted in developing statewide plans and key persons were trained to increase the involvement of business, industry, and labor in vocational education personnel development. In this era of tight resources and rapidly changing technology, colleges and schools have been provided models of industry and education sharing resources for their mutual educational and financial benefit. Exemplary programs in 138 colleges from 39 states are identified and described in a report prepared for other institutions who want to increase their collaboration with industry, especially in the sharing of facilities, equipment, materials and personnel.

The National Center is a central resource for the states sex equity coordinators. Training materials developed by our staff were used in 6 regional workshops in the spring of 1978. These materials were widely used in the states following the workshops. Over 1,200 copies of Vocational Education Sex Equity Strategies have also been disseminated to counselors, teachers and administrators to improve classroom conditions. In addition to those copies, all the states reprinted all or part of these materials. For example, Wisconsin disseminated 1,500 additional copies of the Strategies. Additionally, research has been conducted on ways of increasing nontraditional enrollments.

Our Performance-Based Teacher Education (PBTE) effort is making direct impact upon the quality and relevance of vocational teacher training programs. This program, which focuses upon the development of specific professional skills that are needed by vocational teachers, provides hundreds of universities, colleges, community and junior colleges, local school districts, businesses and industries to redirect teacher and instructor training programs to focus upon essential teaching competencies. The PBTE module series is being expanded to better prepare teachers to serve all students within their vocational classes such as the handicapped, disadvantaged, nontraditional students, individuals with limited English proficiency, and adults pursuing retraining.

LEADERSHIP DEVELOPMENT

Through the Advanced Study Center and the National Academy leadership development activities have been carried out which have involved all states and many local communities.

To date, the National Academy has conducted 112 programs in 32 states. The 4,165 participants of these programs have come from every state and territory, and represent personnel from both the public sector and business, industry and labor; the common denominator being an interest in maximizing the efficiency and effectiveness of the nations work-force by providing more accessible, responsive, and sophisticated work-related training systems in the United States.

The National Academy's In-residence Program provides an opportunity for vocational leadership personnel to foster their leadership and professional development as well as contribute to the profession through a residency experience at the National Center. Each participant engages in an individualized program of development, which utilizes the many human and material resources available at the National Center and The Ohio State University. To date 92 persons have participated in the In-residence Program. Participants have come from 31 different states, the District of Columbia, Trust Territories of the Pacific Islands, and thirteen foreign countries. They focused on such topics as program development for the disadvantaged and handicapped, and CETA/Vocational Education linkages.

Twenty-three Advanced Study Center Fellows from 18 states, 14 disciplines and a variety of institutional settings have conducted research studies and pursued their professional development on signficant problems facing education for work. Over time, the impact of the Fellow's leadership and publications will contribute materially to program options, policy development, and more responsive programs. For example, one Fellow developed an institutional planning model for postsecondary institutions that has, in very brief time, been adopted by 30 institutions throughout the nation.

We are inaugurating an Executive In-Residence Program which will enhance our leadership development program, by bringing to the National Center executives from the private sector who are responsible for industry-based training programs. During their period of residence they will be developing plans for improving their own training program, interacting with researchers on ongoing programs and developing a better understanding of vocational education programming.

INFORMATION FOR PLANNING AND POLICY

The National Center is responsible for developing information that will be useful to the Congress in the authorization and appropriation processes and to the administration in considering policy options. Following are the major activities in which we are engaged.

An exhaustive search to identify, assemble, evaluate, and synthesize all studies on the effects of vocational education, reported from 1968 through 1979, has been completed. This effort represents the most comprehensive report currently available on the effectiveness of vocational education.

The National Center, for the first time, is collecting high school transcripts of participants to examine the effects of vocational education according to the amount of vocational instruction completed in high school. This will produce the most accurate information available on the effects of secondary level vocational education. We are also conducting a study on the longer term effects of secondary and postsecondary vocational education by using a nationally representative sample of 1,500 workers, age 20-34. This will enable us to extend our knowledge on the longer term effects of vocational education and other educational experiences.

Efforts toward strengthening our capacity to tap large-scale databases for policy analysis and research, have resulted in the establishment of a data file consisting of eleven major statistical databases. This data resource contains information on outcomes, enrollments and operations of vocational education, which can be manipulated to answer administrative and policy questions.

EVALUATION

Since 1979, the National Center has been conducting research on the educational, economic, and socio-demographic factors affecting the placement of vocational education students in jobs related to their training. Data are being collected for this study from eleven states, using sixty-two secondary education agencies, and thirty-two postsecondary education agencies. The study will result in the identification of variables that can be manipulated by administrators and policy makers to enhance job placement.

The National Center has developed nine evaluation handbooks designed to improve the quality of vocational education evaluation methodology and to provide vocational educators with ready-references for planning and conducting evaluation efforts. Several national workshops have been held to secure use of these handbooks. The handbooks provide information about such critical issues as follow-up of former students, including special populations; the auditing model as a technique that state advisory councils can use in evaluating vocational education programs; assessing employer satisfaction with training; assessing job satisfaction of vocational education students and their satisfaction with the vocational training; and the utilization of evaluation information. An evaluation handbook on vocational education in correctional institutions will be available by January 31, 1982.

The National Center is currently working with the National Occupational Information Coordinating Committee (NOICC) in ten states to determine undercounting and duplication of counts in reporting enrollments of individuals completing vocational education programs sponsored by various sources of state and federal funds. The results of this study will be available by September, 1981.

CLEARINGHOUSE

In three years, the National Center's Clearinghouse has made it possible for vocational educators everywhere to find out about every program improvement project funded under national vocational education legislation since 1970, whether state or federally administered. This service fosters more rapid and extensive use of program improvement reports and helps eliminate unnecessary duplication.

The Clearinghouse has developed bibliographies of the 1,285 federally administered and 6,668 state administered projects conducted between 1970 and 1977, and reports about projects conducted in 1978, 1979, and 1980. It also has announced currently funded projects in the bimonthly Resources in Vocational Education, which is distributed to nearly 2,000 vocational education leaders.

The Clearinghouse has developed an online computer file of information about program improvement projects funded under the current legislation. As project reports and product outputs become available they can be matched against projects for accountability purposes by state and federal agencies. Even more importantly, it is now possible for R&D specialists, administrators and others to 1) make contact with project personnel while projects are underway, 2) avoid duplication of current efforts, and 3) benefit from work while it is still underway.

The Clearinghouse has been maintaining liaison with four branches of the Department of Defense and the Coast Guard, acquiring relevant military-developed curriculum, and making these available in microfiche at 40 instructional materials laboratories throughout the country. In addition, the Clearinghouse staff has begun planning and feasibility testing on the instructional materials database to provide a much needed supplement to existent systems.

DISSEMINATION AND UTILIZATION

The dissemination and utilization program has increased vocational education's capability to select and use the best available products and information for program improvement. This has been achieved by the systematic screening of over 15,000 products developed throughout the country. Of these 15,000 products, 160 were identified and publicized for their potential impact on priority problems, and 20 were selected for nationwide dissemination and utilization emphasis.

In three years, 31 major review and synthesis papers on such critical issues and problems as basic reading and mathematics skills in vocational education and the role of vocational education in facilitating productivity were published. These papers have become extremely useful to the field because they integrate information from a variety of sources into useful forms for users.

Over 45,000 copies of the 20 selected exemplary products and the 31 knowledge transformation products have been requested from all states for specific use. In a recent survey of persons who had received these products, we learned that 93 percent had read them, 69 percent had implemented some aspect of them, and 64 percent had used them with students.

Many of the products have been further reproduced for use at state and local levels. For example, the Texas Education Agency reproduced and distributed 19,500 copies of Guidelines for Sex Fair Vocational Education Materials, a product which was selected by the National Center for nationwide dissemination, and which was developed under a federally administered contract by Women on Words and Images in Princeton, NJ. Over 100,000 promotional items and a newsletter have been used to increase field awareness of these 51 products.

Over 10,415 persons have participated in 492 field events, which were either conducted or facilitated by the National Center's D&U program in an effort to introduce these products, train disseminators, and train product users.

Outreach to the field is accomplished by various means. Last year workshops were held in six major cities to introduce teachers and administrators to National Center products and services. Over 1,200 school personnel in Los Angeles, Philadelphia, Atlanta, Houston, New York, and Chicago attended these workshops. The workshops were geared to the special needs expressed by vocational education personnel in each of these cities. Additionally, five workshops were held in the states of Nebraska, Texas, Virginia, Iowa, and Wisconsin where 465 participants received information and materials from the National Center.

National and State Occupational Information Coordinating Committees

The 1976 Amendments charged NOICC to 1) develop and implement a national, state and local occupational information system to meet the common occupational information demands of vocational education employment and training program administrators and planners, and 2) improve coordination between, and communication among, such administrators and planners, as well as employment security agency administrators, research personnel and others. NOICC is also required to assist the SOICC's in implementing an occupational information system. NOICC activities are mandated by the Education Amendments of 1976 and the CETA Amendments of 1977 to receive not less than $3 million, nor more than $5 million from each Act.

Today, SOICCs are operational in the 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the Northern Mariana Islands, the Virgin Islands and the Pacific Trust Territories. As of 1980, NOICC has established three major grant programs to support SOICC activities: SOICC Basic Assistance grants, Special Purpose Project grants, and Career Information Delivery System grants. The implementation of the Occupational Information System (OIS) in all states has been accomplished with the cooperation of many organizations at all levels, and many of these individual data collection efforts are so large that integration of the components into a standardized system will continue to require considerable study and analysis. A three volume OIS Handbook has been produced that contains technical descriptions of each OIS information element and data source, and methods of integrating available data and information for supply/demand analysis. Fifteen states have established Career Information Delivery Systems for the purpose of delivering this occupational, educational, and training information to persons who are in the process of career exploration and decision-making, especially to students and out-of-school youth.

The Secretary's Contracts and Grants

Funds reserved for the Secretary in this appropriation category are used to sponsor national competitive awards to focus the nation's talent on problems of national significance. This provides one of the most effective means for the federal government to assure that quality research programs, curriculum development, and personnel training are identified, developed and used in a variety of operational settings to address such priorities as economic development, productivity, equity and youth unemployment. State program improvement activities frequently build upon this federal investment. Six regional curriculum coordination centers are supported with funds from this section. They form a national network for dissemination, curriculum management and liaison with the fifty-seven states and territories.

Other activities currently underway include the development of energy conservation instructional materials, the improvement of related instruction in apprenticeship programs, the design of a national cost benefit study of secondary, postsecondary and adult levels, and the identification of vocational education personnel development needs for working with the handicapped.

Training and Development Programs for Vocational Education Personnel

This appropriation category provides for the training and development programs for vocational education administrative and professional personnel. Individual awards for up to three years of graduate study are provided under the

Vocational Education Leadership Development Programs to prepare leaders for key roles. The Vocational Education Teacher Certification Fellowship Program provides opportunities for certified unemployed teachers, who have been trained to teach in other fields, to become vocational teachers. The program also provides opportunities for persons in business, industry and labor to become vocational teachers. These investments expand the national pool of talent and attract, prepare and retain some of the best minds in the nation to provide leadership in a variety of program settings.

Conclusion

Programs of National Significance, vocational education's program improvement capacity, supports several congressionally mandated support services that catalyze and impact on federal, state and locally funded efforts. The National Center for Research in Vocational Education, the National and State Occupational Information Coordinating Committees and other elements funded under this category, collectively contribute to the quality, relevance and utility of vocational education programs. In my view, national program improvement is a most appropriate federal role. The new challenges of economic revitalization, productivity, contributing to the national defense effort and maintaining our commitment to access and equity will require continuing and sustained efforts on behalf of the National Center for Research in Vocational Education, the State and National Coordinating Committees, and other elements funded by Programs of National Signficance.

This category is substantially below the five percent set aside called for in the legislation. Any further reductions compounded with inflation and several years of level funding would severely restrict our ability to fulfill our mission. It would disrupt ongoing efforts, fail to capitalize on prior investments, erode the strength of state and federal sponsored program improvement activities and constrain our ability to utilize outstanding R&D. The ability to build on and utilize the work of other states would also be greatly restricted. Increasingly there are products from research, development, training, evaluation and planning efforts funded at both the national and state levels which should have greater utilization through national dissemination strategies. Unfortunately funding for dissemination competes for the same dollars needed for current high priority research, development and training efforts focused on problems of national significance.

STATEMENT OF JOANNE GOLDSMITH

On behalf of the Board of Directors and members of the National Community Education Association, I want to thank you for the opportunity to testify today regarding federal funding for community education for fiscal years 1981 and 1982.

A part of the Educational Ammendments of 1978 (PL 95-561), Title VIII--The Community Schools and Comprehensive Community Education Act--authorizes the expenditure of $123 million for fiscal year 1981, and $99 million for fiscal year 1982. The total authorization over the five-year period of the legislation is $478 million.

The Fiscal Year 1981 Continuing Resolution includes a $10 million appropriation for community education. In his budget message of March 10, 1981, President Reagan recommended to the Congress that it rescind $6.862

million of the $10 million appropriation, leaving a revised budget figure of $3.138 million for fiscal year 1981.

President Reagan's rescission request represents a 69% cutback from the appropriation in the Fiscal Year 1981 Continuing Resolution. Such a large cutback would drastically reduce the number of people who would be served by this program.

The $10 million appropriation would open an estimated 200 new community schools which would serve approximately one million people. The 69% cutback proposed by President Reagan would eliminate 115 of those new community schools and eliminate programs for an estimated 400,000 people.

The Fiscal Year 1981 Continuing Resolution allocates the entire $10 million to Section 804: State Community Education Programs. Provided as Attachment A is a listing of the amount each state would receive if the funding remains at the level approved by the Congress. It should be noted that 80% of the funds would be passed on to local education agencies.

Earlier evaluation studies of the federal community education program have documented the effectiveness of the program in meeting congressionally-mandated objectives. As independent evaluation conducted recently for the U.S. Education Department's National Community Education Advisory Council provides dramatic new documentation of the impact of the federal programs on community education development within the state education agencies. Conducted by Developmental Associates of Arlington, Virginia, the study assessed the impact of federal support on the capabilities of the SEAs in community education development. The report dated February 12, 1981 stated in part:

> "The broad range of findings support the conclusion that the Federal Legislative mandate was met and that the states have been quite successful in developing state community education programs capable of expanding and supporting community education programs."

The decision of the Congress to allocate $10 million to Section 804: State Community Education Programs was justified on the basis of the recently completed evaluation, which documents the capacity of the SEAs to administer the approved state formula program.

The National Community Education Association is not requesting an increase in federal funding For fiscal year 1982. Instead it recommends a funding level of $10 million as approved in the Fiscal Year 1981 Continuing Resolution.

The National Community Education Association supports President Reagan's desire to cut back on the level of federal spending and at the same time support programs that are cost effective and efficient. The federal community education program has demonstrated its effectiveness in cutting down waste as well as adding to our country's productivity in the following ways:

1) Community schools offer job training programs, courses for high school equivelency diplomas, job counseling programs, marketable skills-building programs, and job placement and referral services to a wide range of citizens of all ages and educational backgrounds.

2) Community schools are energy-efficient In most cases the local school is within walking distance for the program participants. Recent studies indicate that keeping school buildings open for longer periods each day does not substantially increase energy use. In fact, considering the energy savings in the homes of those attending extended school-day programs, community schools actually reduce the total amount of energy used in the community at large.

3) Using the community school as the central location for delivering local social services reduces the cost of delivering such services by eliminating the need for separate offices or buildings for each of the agencies involved.

4) Using surplus school space for the delivery of local social services (for example, senior centers) makes good economic sense in the long as well as the short term: besides being cheaper than acquiring new space, it serves to retain public school facilities in the public sector against the possibility of changing population patterns and changing enrollment needs.

5) By involving a broad spectrum of citizens in a variety of educational programs, community schools help to maintain local public support and understanding of public education at a time of declining enrollment, when the majority of citizens are non-parents.

Mr. Chairman, I appreciate the opportunity to appear before you today and will be pleased to repond to any questions that you or members of your subcommittee may have at this time.

Allotment of funds under P.L. 95-561, Title VIII, Community Schools: FY 1981 (FY 1981 appropriation)

	State amounts 1/		
.S. and areas	$10,000,000·		
0 States, D.C. & P.R.	$ 9,900,000·		
labama	162,247·	ew Jersey	318,401·
l	50,000·	ew Mexico	52,878·
rizona	103,276·	ew York	772,328·
rkansas	94,311·	orth Carolina	242,457·
alifornia	971,134·	orth Dakota	50,000·
olorado	117,768·	hio	467,070·
onnecticut	135,612·	klahoma	123,731·
elaware	50,000·	regon	106,714·
lorida	376,938·	ennsylvania	511,940·
eorgia	220,870·	hode Island	50,000·
awaii	50,000·	outh Carolina	126,299·
daho	50,000·	outh Dakota	50,000·
linois	489,092·	ennessee	188,578·
ndiana	234,449·	exas	567,822·
owa	126,473·	tah	57,317·
ansas	102,144·	ermont	50,000·
entucky	151,889·	irginia	225,309·
ouisiana	173,128·	ashington	165,076·
ai	50,000·	est Virginia	80,993·
aryland	180,526·	isconsin	203,810·
assachusetts	251,161·	yoming	50,000·
ichigan	399,569·	istrict of Columbia	50,000·
innesota	175,129·	uerto Rico	139,486·
ississippi	104,843·		
issouri	210,947·		
ontana	50,000·	reas and B.I.A.	$100,000·
ebraska	68,285·		
evada	50,000·		
ew Hampshire	50,000·		

1/ Allotment of $10,000,000 with 1% reserved for the outlying areas and B.I.A., and the balance distributed on the basis of the total resident population, 7/1/78 for the 50 States and D.C., 1976 data for Puerto Rico, with no State receiving less than $50,000.

STATEMENT OF DR. GARY A. EYRE

I am Gary A. Eyre, Executive Director of the Council. I appreciate this opportunity on behalf of our Council to submit this written statement in support of a level funded appropriation of $122.6 million for each budget year of FY-81 and FY-82.

The state grant program, under the provision of the Act, is an advance funded program. The FY-80 budget for the program year of July 1, 1980, to June 30, 1981, is currently in operation at a Federal appropriation level of $122.6 million.

The Continuing Resolution (FY-81 budget for the FY-82 program year - July 1, 1981, to June 30, 1982) was proposed at a $120 million level. The Budget Revisions document signed by the President and submitted to Congress on March 10, 1981, recommends a $30 million rescission which represents a 25% cut and would make available $90 million for the Federal Adult Education Act in the 1982 program year.

The President's recommendation for the FY-82 budget (FY-83 program year, July 1, 1982 to June 30, 1983) is $94 million within a local education agency block grant concept.

The issues of a block grant package can not be adequately addressed at this time since the administration's bill on consolidation and block grants is not fully formulated.

The Advisory Council will, at the appropriate time, submit its recommendations to the President and Senator Hatch and his Committee on the matter of Federal policy for adult education and the block grant design.

Over the past sixteen years, the Congress of the United States and each administration, both Republican and Democrat, have been deeply concerned with the level of illiteracy among America's adult population. This concern was the genesis for the Federal Adult Education Act of 1965, and is presently within the statute of P. L. 95-561, the Education Amendments of 1978.

The target population of this legislation is adults sixteen years of age and older not currently required to be enrolled in school and who lack sufficient mastery of basic educational skills to enable them to function effectively in society or who do not have a certificate of graduation from a school providing secondary education.

In a nation which prides itself on 12.4 median years of school completed - a nation where over 90% of its young people are in elementary and secondary education, the question of the need for adult basic education surfaces. The causes of illiteracy are numerous and intertwined with many variables - the effects of illiteracy are self-evident. No one can point a finger at any one cause. Regardless of multiple causes, there has been and, unfortunately, there is an American adult illiteracy problem.

As the decade of the 1980's begins, America finds in its midst over 50 million persons of labor force age not enrolled in school and with less than a high school education.

Comprised of both men and women, of all age groups, of whites and blacks, of the Spanish speaking, of Indians and persons of othe races and origins and located in all sectors of the nation, these people have two denominators: (1) a lower than average school attainment, and (2) a higher than average number at the lower ranks of our economy and our society.

For example:

- Lower levels of education serve as a major barrier to being able to work at all.
- Lower levels of education generate higher rates of dependency, such as public assistance.
- Even when able to participate in the labor force, those with under par schooling show significantly higher rates of unemployment and higher proportions in part-time work than their counterparts with a high school diploma.
- A new occupational and industrial environment in America can bring about major increases in job opportunities in the professional, managerial, clerical, sales and skilled occupations and in the service producing sectors of the economy. These are fields where demands for more education have taken place, hampering millions of adults with less than 12 years of school from moving into expanding job fields.
- The jobs requiring more educational competencies are the higher paying ones. Those with less schooling experience, smaller earnings.
- Americans move in large numbers and proportions, mostly in response to economic opportunity - to get a job, a

new job, a better job. The higher rates of migration are found among those who have the higher levels of education, indicating that millions among this group do not have the mobility to respond to the changing geography of employment opportunity.

- Technological development in a country depends on the quality of its labor force, and particularly on training and education. In turn, technology affects the kinds of jobs which a country provides for its workers. The evidence shows that a trained and educated work force finds better jobs and more job satisfaction.

Thus, those adults left behind on the educational front are at a severe disadvantage in the current world of work. The prospects are as bleak for them for the rest of the current decade as well as for the 1990's unless we continue our Federal financial effort at a level of dollar commitments made in the 1981 program year.

President Reagan's message to Congress on February 18 and his economic recovery plan, translated into hard budget facts on March 10, outline a strategy for stopping runaway inflation, the revitalization of our economy, and increasing productivity. A basic economic fact of life is that an educated labor force is a prerequisite to economic progress. Adult basic education is not, nor should it ever be considered, a "basic social safety net" program. It has as its stated Congressional purpose to expand educational opportunities for adults and to encourage the establishment of programs of adult education that will —

(1) enable all adults to acquire basic skills necessary to function in society,

(2) enable adults who so desire to continue their education to at least the level of completion of secondary school, and

(3) make available to adults the means to secure training that will enable them to become more employable, productive, and responsible citizens.

The program is a partnership effort between local educational agencies, community based organizations, the state, and the Federal government. This partnership is not a one-sided endeavor with Federal tax dollars being allocated disproportionately to state and local funds. The Federal dollar generates twice the overmatch requirement.

The National Advisory Council on Adult Education recommends that this Senate Subcommittee, in light of the need to increase our national economic growth and upgrade our work force, give strong consideration to maintaining at least level funding of the Adult Education Act in order that adult citizens who are willing to join the labor force are able to do so because they now possess basic educational competencies.

Adult education has a stake in moving away from economic stagnation.

STATEMENT OF DR. JAMES R. DORLAND

I am James R. Dorland, executive director of the National Association for Public Continuing and Adult Education (NAPCAE), and I am pleased to present this statement in support of adequate funding for the Adult Education Act for Fiscal Years 1981 and 1982. I also chair the Legislative Committee of the Coalition of Adult Education Organizations (CAEO), which is composed of 25 national professional and consumer organizations interested in and working with adult learners. Our Association also works closely with the National Advisory Council on Adult Education on matters of mutual interest.

It is my privilege to represent NAPCAE today. We also have three major groups affiliated with us -- the National Council of State Directors of Adult Education, the National Council of Urban Administrators of Adult Education, and the NAPCAE Council of Affiliates, which is just concluding a three day meeting here in the nation's capital. The thousands of members of these various groups comprise the overwhelming majority of the people responsible for developing, supervising, teaching in, and carrying out the programs which have been funded under the Adult Education Act since it was first passed in 1966.

The current NAPCAE president is John Ryan, Hartford, Connecticut; the chairman of the state directors' council, William Moore, Richmond, Virginia; the president of the urban administrators' council, Harold Wilson, Indianapolis, Indiana; and the president of the affiliates' council, Wade

Waters, Savannah, Georgia. Chairing the NAPCAE Legislative Committee is Mary G. Turner, Washington, D.C.

My statement today deals with the funding of the Adult Education Act in fiscal 1981 and 1982. This legislation is focused upon a target population which is composed of adults sixteen years of age and over not currently required to be enrolled in schools and who lack sufficient mastery of basic educational skills to enable them to function effectively in society or who do not have a certificate of graduation from a school providing secondary education. We are speaking specifically of a target population of some 53.3 million adults who have not completed high school and some 21 million adults who lack the basic competencies to enable them to function effectively in today's complex society. We are talking about a fantastically successful educational enterprise which has kept its national average cost at less than $2.00 for each hour of adult education instruction.

Overall the story of the Adult Education Act is one of solid, steady increases in funding and in impact over the years. The Act itself has been consistently amended and extended since it was first passed in 1966. The 1978 amendments, as found in Public Law 95-561, and the subsequent Rules and Regulations which were released last year -- called for a significant expansion of the adult education delivery system, with the emphasis continuing to be directed to those who are most in need of basic education. They are the hardest to reach and the most difficult to teach. As a result of those 1978 amendments, encouragement has been given to community-based organizations to become active in offering adult education programs. These new initiatives were in addition to the longstanding services which have continued to be provided by local educational agencies.

From all indications -- including GAO reports and an assessment completed last year for the Department of Education by Development Associates -- the Adult Education Act has been

been the leading force in the evolution of what has become a remarkable delivery system for the education of adults. In this delivery system, all three units of government -- federal, state and local -- have had functional roles, and none has become dominant.

Each year this impressive record of adult education partnership is documented in NAPCAE's Public Continuing and Adult Education Almanac. I am including as an attachment to my testimony a copy of our 1980 Almanac. The information found on pages 27-35 is evidence of the continuing existence of this healthy adult education partnership. However, this pattern of steady, responsible growth is threatened by the proposal of a substantial cutback in federal funding. Let us now turn specifically to those proposed funding levels for this year and next:

Funding for Fiscal 1981

As you know, the Adult Education Act is one of the programs which is advance-funded. Therefore, during this current fiscal year, the Adult Education Act programs are operating under the appropriation which was passed by Congress in 1980, and which is $122.6 million -- $100 million in grants to states (Section 315a), $2.5 million for the Indochina refugee program (Section 317), and $20.1 million for the immigrant program.

The Adult Education Act was included at that same $122 million level in the 1981 continuing resolution which was passed near the end of the 96th Congress. We learned on March 10 that the President has requested a 25% rescission in fiscal 1981 funding for most education programs. For the Adult Education Act, the figure would be $90 million for the total appropriation. As a forward-funded program, if enacted into law, this $90 million national funding level for the Adult Education Act would go into effect during fiscal 1982. This would mean that locally-operated adult education programs would suffer in two major respects -- from the ravages of constantly escalating costs, and from a 25% reduction from their present level of operation.

We are well aware that the current administration has launched a major effort to reduce expenditures and to strengthen our economy. We are also aware that a key feature of any economic recovery program is increased productivity. Basically, this can be done in two ways: by using new and more effective machines to produce goods, and/or by making better use of existing resources, especially human resources. The Adult Education Act places its total emphasis on the improvement of those human resources.

To date the economic benefits from the Adult Education Act have been countless in the millions and millions of dollars in savings resulting from people being removed from public assistance, from earnings for people who became employable through adult education, and in increased earnings for people who were promoted in their jobs as a result of their participation in classes funded by the Adult Education Act. That kind of benefit is a direct stimulus to our economy and should be continued at the maximum level possible.

Therefore, we recommend level funding for the Adult Education Act in fiscal 1981 (for expenditures in fiscal 1982) at the same $122.6 million figure under which the program is currently operating. This would involve no increase in expenditures which have already been approved.

Funding for Fiscal 1982

Our basic recommendation for fiscal 1982 (for expenditure in 1983) is for the Adult Education Act to be funded at the the same $122.6 million figure which it is receiving this year. In effect, this would result in three consecutive years at that same level, which would be in keeping with holding the line on expenditures and making better use of existing resources.

In his budget recommendation to Congress on March 10, the President also unveiled his proposals for ending a number of categorical education programs and folding them into *two block grants, one to local education agencies and one to state education agencies. We are aware that it is not the province of this appropriations subcommittee to make decisions concerning authorizing legislation. Therefore, in this testimony we are not speaking to the issue of block grants. When such legislation concerning block grants is introduced, NAPCAE and its affiliates will study such legislation carefully and will then become involved in the legislative process where appropriate.*

For fiscal 1982 Adult Education Act funding, our recommendation is that $122.6 million in federal funds be made available for such programs regardless of the delivery system. Of course, we must admit to a certain bias that the delivery system which has been in place since the mid 1960's has proved to be an effective one.

In conclusion, I wish to say smply that we are requesting the maximum level of funding available for the truly needy adults who are the potential recipients of adult education. I can assure you that adult educators will continue to be prudent stewards of whatever funds are made available to them. We have tried to be responsible and pragmatic in our funding requests. Thank you for receiving this statement.

STATEMENT OF STEVE LEIFMAN, NATIONAL DIRECTOR, NATIONAL COALITION OF INDEPENDENT COLLEGE AND UNIVERSITY STUDENTS

Senator BURDICK. The next panel will be the student financial assistance. Introduce yourselves and proceed as you wish.

Mr. LEIFMAN. Thank you very much. My name is Steve Leifman, national director of the National Coalition of Independent College and University Students. I appreciate our written statement to be accepted for the hearings and also I would like to ask that the statements of Bill Lash and Don Salarvi, two students that have written two-page statements, be submitted for the record, also.

Senator BURDICK. Without objection, it will be received.

Mr. LEIFMAN. I would like to thank you for the opportunity to be here. Our coalition is a national organization based in Washington, D.C.; it has chapters in campuses across the country. The commitments made by Congress in recognition of the need for aid was seen 2 years ago, and less than 1 year ago with the passage of the 1980 amendment. These two acts recognize the continued burden of tuition increases, as well as the recent phenomenon of disenfranchisements of class.

The coalition has held that high costs restrict the education only to the wealthy and applies to the Congress for their commended educational opportunity.

Now, less than 6 months after the higher education bill became law, we encounter a budget-cutting hysteria that threatens not only to undermine the intent but threatens to deny hundreds and thousands of students the education the Federal Government 4 months ago promised.

Since we do have such a short time, I would like to touch on quickly basic grant program and a major problem that we are facing right now with shortfalls. It says that the program is the cornerstone of the financial aid, is seriously challenged, those major shortfalls in the program to the tune of about $1.4 billion.

Administration has proposed a supplemental $661 million, assuming a maximum award of 1,750. Unfortunately, however, even there is 1,750 maximum awards made on the assumption that their proposed cuts are going to go through and eliminate quite a few students on the program.

Even if these cuts go through, it appears that the Reagan administration proposals are still going to be short quite a few million dollars. What we figure will happen is we will have a two-hit system on the students.

In effect, it's going to be disproportionately affecting students in independent colleges. The way that the Reagan administration is proposing now is giving Congress 45 days to approve or disapprove a regulation that will not index for inflation.

The first problem with that is it is totally turned off the basic processing system which will make it impossible for students to know what their intended aids will be before they go home this summer break.

Over 5 million students have already applied. The effectiveness will be that students will come back in the fall, having no idea their aid is going to be, worked as much as they thought they needed to over the summer, there will be major shortfalls.

The experience of that is just going to be just devastating. If I can just finish this point.

The other problem we have seen right here is that the administration—there is another mechanism in the current system that would allow for the current processing of the basic grants to go on while at the same time if Congress still thought it necessary to cut the programs to be able to cut the programs without causing this trauma and chaos that they are putting into the system.

The current system is known as ratable reduction. That allows Congress to continue to process the basic grant program and then at the last minute they feel it necessary to cut the money, they can just go ahead and take the money out of the program.

We would urge that Congress defeat the regulation that the President has put forth to you in order to get the system going again. By not adjusting for inflation which the President is asking, this means that Congress would not be adjusting for not this past year's inflation, but the year before, and also the year before that.

All right. Costs have been going up in our schools increasingly; this year we expect it to go up about 15 percent, which make the average cost in an independent school about $7,500.

Then if you would defeat this amendment and you still thought it necessary, we would appreciate if you would use the current system with some modifications in the ratable reduction formula which at this point is very native or adverse to students at independent colleges.

I appreciate your time and I am sorry we couldn't touch upon some of the other points in the guaranteed students loan program. Thank you.

Senator BURDICK. Thank you very much.

STATEMENT OF EDUARDO WOLLE, LEGISLATIVE DIRECTOR, UNITED STATES STUDENT ASSOCIATION

Mr. WOLLE. Thank you for the opportunity to testify. I am the legislative director for the United States Student Association. We represent 3.5 million college and university students across the Nation, including students from your State.

We, as students, are concerned with the possibility that if Congress accepts the administration's budget proposal, all of the advances that have been made through the Middle Income Students Assistance Act, provide an easier access to college for lower income students and statewide student loans programs and in allowing a healthy competition between public and private sectors have been an exercise in futility.

We would like to echo our colleague's recommendations that he answered, and we would like to go a little bit further.

It is presently underfinanced as Steve said. They claimed figures that we have seen from the congressional budget, say, that for a 1,750 maximum you would need $911 million. Presently, for an 1,800 maximum, with Congress in the continuing resolution made its intent to be, you would need about $1.2 billion for that. The House full Committee on Education, Labor, yesterday decided to back that, also.

The administration requests a supplemental for $661 million. We do not feel that that figure is accurate and that it should be nonsupported.

However, should Congress not adopt one or all of the administration's proposals, there would be a tremendous shortfall in the program. With that $661 million, you would have the possibility, also, with the social security cut, you would have 250,000 students becoming newly eligible for the program and you would end up not being able to finance them because of the shortfalls in the program.

For the fiscal year 1982, we would like to recommend a 1981 maximum award for the program. Just in summary, the program as it is now, would not accommodate the students. It was a cut last year of $140 million and what is being talked about for this coming year, was a 1,750 maximum, and the possibility that if nothing happens dropping down to 1,250 would have devastating effects on colleges, universities and students.

Thank you.

Senator BURDICK. In reading the newspapers, I find one of the objections seems to be the eligibility of student loans with regard to family income. Do you have any comment to make about that?

Mr. WOLLE. Again, Congressional Budget Office had mentioned that with the needs has 50 percent of those students presently on the guaranteed student loan program who would be eliminated.

With the interest subsidy being eliminated, you would have at least 25 percent of the students, so you are talking about 75 percent of the students out of 2 million students who were on guaranteed student loans being eliminated. That is our concern.

We have been throwing around figures and the administration, Congress, everybody has been throwing around figures, but nobody is throwing around the figures of how many students are going to be affected by this legislation.

That is our concern.

Senator BURDICK. Do you think there should be a needs test at all?

Mr. WOLLE. No, I don't.

Mr. LEIFMAN. May I also address that question? We think the concept of remaining need that the Reagan administration approached is a good one. Unfortunately, the way it would be carried out would have some very adverse affects. One of the initial problems with the remaining need idea is you have a lot of students that would have, especially at the low-cost institutions, remaining need of, say, $200 or $300. Well, it costs the banking institutions the same amount of money to process a $200 loan as the $2,500 loan, but the yield would be lower and they would lose out and probably not loan to this student with the loan need.

The Reagan administration would then say, well, this student's parent could go get a parental loan, but they also want to raise the interest rates on the parental loan to Treasury bill plus 3 percent, which we feel would be a disincentive for the parent to loan.

With the national direct student loan being cut back, it is going to hurt about 35,000 people. So the student with the lower remaining need probably will not be able to even get an NDSL as an alternative.

So a remaining need, if it was workable, and we could assure the banking institutions will stay in and the interest rate on the parental loan program would be increased to the point where it would be a disincentive, there may be some merit.

Mr. WOLLE. I would like to make one point on that, also, and that is the national direct student loan is already need-based and is a 4 percent low interest loan. What you would be doing, in essence, is having two need-based loans and saying that more low income people would be put into the guaranteed student loan.

That is something that concerns us also is that you are shifting more of the burden onto the needier people, onto the poorer people, by saying you have to take out guaranteed student loans if there is a shortfall in the program. So that is another one of the incentives.

Senator BURDICK. What do you think of a cap on eligibility under the interest subsidy, under the old law?

Mr. LEIFMAN. At the levels last year—excuse me, before MISA, it would probably be too low because inflation has knocked quite a few people. The Congressional Budget Office estimates that in order for a cap to be equivalent to where it was pre-MISA, it would have to be at a $40,000 level.

If it is an easier way and you still can assure that needy students and middle-income students won't be squeezed out because of that, I think it has some merit.

Mr. WOLLE. I don't think that we would be really in favor of an income cap because that would be defeating the whole purpose of the legislation enacted in 1978, which, in effect, took that cap off and made the loans available to people.

We feel that by that step, the Congress and the United States was saying, in effect, that we are opening up education to just about everybody, regardless of income. We do agree that there should be some limitations and there has been some abuse in the program, but that has been blown out of proportion as the press said, and I don't think it is as bad as spoken about.

Senator BURDICK. We will go to the last member of the panel.

STATEMENT OF DR. WAYNE BROWN, EXECUTIVE DIRECTOR, TENNESSEE HIGHER EDUCATION COMMISSION

Dr. BROWN. I am Wayne Brown, executive director of the Tennessee Higher Education Commission, and with me is Michael Goldstein, counsel for the State Higher Education Executive Officers, a national organization of my counterparts.

In general, Mr. Chairman, we have responsibilities related to student aid as well as State funding, and I will speak from that perspective. I will comment about some of your questions on the GSL in just a moment.

Many States are ill equipped to face what may happen if both the changes that are being discussed with the GSL and the modest reduction in the grants take place. The reason many States are ill equipped is that $1 dollar taken from the students amounts in many States in more than $1 from the institution.

In our case, we are still growing in student enrollment in public education. But because of the recession, and Tennessee's tax base, we are seeing the money spent, appopriated and being spent per student is declining.

It is due to two reasons that actually there is less money spent per undergraduate in State money at the University of Tennessee at Knoxville, as one example, than was the case 5 years ago. It is because of the rapidly growing community college system, State and Federal mandated new programs such as a new medical school through medical funds.

That is where many of our dollars have gone. Now, that is not directly Congress fault, but my point of mentioning that is simply to say this: The States are facing with growing enrollments in many cases, declining State revenues allocated to education. In our case, we have gotten 17 to 18 percent in the State budget for 10 years. That is not our problem.

Our share of the pie is constant. The problem is the State pie is not large enough because of inflation. We support Congress' effort in that presence to stand back. I would like to point out in the case of the GSL, our position in Tennessee and the position growing among our counterpart officers nationally is we would support the imposition of a family income eligibility index.

We are thinking in terms of roughly $30,000. What we are concerned about, the critical change that is being proposed is the imposition of a needs test by a mechanism which we feel needs to be reconsidered.

We also are concerned that the manner in which the interest subsidy will not be continued during the time the student is in school, is a major factor. Lenders in our State are telling us and lenders that I have had to fight hard as vice president of the Student Assistant Corp. to get in the program are telling us they don't want to continue the program if that burden is shifted to the students and they have to service it in that manner. I think those problems are very real. We don't think we can continue to give this money to everybody without regard to some of these other factors.

We think that must be considered. But I do think, if I can just have 15 seconds to finish, I do think that the GSL is a major backbone. We have had to fight hard in many States such as ours to get lenders to be in the program at all.

It affects 18,000 Tennesseeans at this time, we are very concerned about what the banks tell us. We are also concerned about the impact of reducing Sally May's opportunity to tap into certain of the resources.

My time is gone, and I recognize that. I want to file an amended and corrected statement with you because of additional thoughts we have had as we had a few more days to consider the proposals.

Senator BURDICK. You get your amendment in. As soon as possible, it will be received.

Dr. BROWN. Indeed.

Senator BURDICK. Thank you gentlemen.

[The statements follow:]

STATEMENT OF STEVE LEIFMAN

Mr. Chairman and members of the subcommittee, I would like to thank you for the opportunity to be here today. My name is Steve Leifman and I am the National Director of the National Coalition of Independent College and University Students (COPUS). The Coalition, now in its seventh year, is a national student organization based in Washington, D.C. with State Student Associations and chapters at independent college campuses across the country.

The committments made by Congress in recognition of the great need for student financial aid was seen just two years ago with the passage of the Middle Income Student Assistance Act (MISAA) and less than a year ago with the passage of the 1980 Higher Education Amendments.

These two historic legislative programs recognized both the continuing burden of tuition inreases on low-income students and their families, as well as the recent phenomenon of the disenfranchised middle-class. The Coalition has long held that rising costs threaten to restrict educational opportunity and choice to only the most disadvantaged (who receive financial aid) and the most affluent. We worked hard in support of both MISAA and the Higher Education bill, welcomed their passage, and applauded the Congress for their committment to educational opportunity.

Now, less than six months after the Higher Ed Bill became law, we encounter a budget cutting hysteria that threatens not only to undermine this Congressional intent, but in addition, threatens to deny hundreds of thousands of students the education the Federal Government four months ago promised. We must point out that students really only get one shot at getting a higher education.

Before launching into our comments, I would like to lay out the important premises on which our concerns have been developed and are offered.

First, we believe that higher education is a necessary entitlement which should be viewed as a vital and distinct social program. Higher education institutions produce social, technical and economic benefits for the entire society.

The success of a democratic society rests on the education of not merely the wealthy, but the whole population. Higher Education builds a well-informed and perceptive citizenry which serves the nation through both their employment and philanthropic contributions.

The many benefits of higher education research are obvious. Our high medical standards and advanced technology are directly related to such research. In addition, as we enter the 80's with an uncertain energy supply, higher education research will serve as the catalyst for finding alternative energy sources.

Economically, higher education has served as a capital investment that produces returns to this country. Any move to cut the higher education on the grounds of reducing inflation would be economically counter-productive. As Prof. Howard R. Bowen reported at a HEW Conference on Inflation and Higher Education:

> "Higher education is not on the whole a significant source of inflation. It does not make heavy demands on scarce resources; it is not at present engaged in ambitious construction programs; it is not a large borrower; it does not make heavy claims on raw materials (for that reason, incidentally, it is not a negligible source of enviornmental plooution); it is not a center of militant trade unionism and is a follower rather than a leader in setting wages; it exercises restraint in setting tuition because, on principle, educators and legislators overwhelmingly favor easy financial access for students; its sources of income other than tuitions tend to lag behind the increases in costs to which it is subject. On the whole, higher education is a sluggish follower and an adaptor to outside inflationary forces, not an aggressive source of inflation."

Colleges and universities are not the villains of the current economic scenario. Rather, they are the victims of inflation: of spiralling energy and labor costs and escalating interest rates.

Independent institutions are particularly hardpressed. They lack the direct state subsidies of the public facilities of higher education, and therefore, must compete for students in an unbalanced market. Tuition at independent colleges is on the average five times greater than that of the public institution. Yet, the true cost of educating a student at an independent or public school is roughly equivalent.

In the end, it is the student that suffers and pays for this unequal treatment. A student wishing to attend an independent college, but lacking the funds to do so, does not receive his net share of this crucial entitlement.

Our second principle follows from the above description. The Federal government by providing access and choice to students of higher education through grants, work-study, and loans is thereby guaranteeing cost-savings and quality education. Presently, the lower and middle-income student does have some choice in whether to attend a public or independent institution. This element of choice produces a beneficial competition. With such a wide range of institutions from which to choose, schools need to maintain the quality of their overall program as well as offer necessary, and often very creative, special programs in order to attract students. Furthermore, to maintain this element of choice, independent schools need to keep their costs and thus tuition down. Public institutions have a similar motivation. If aid is not adequately provided so as to ensure choice, students will only have access to public colleges and universities. This increase in enrollment will only encourage the state legislatures to increase public school tuition. The independent sector will either have to rely on the increased attendance of the upper-income student who can afford the cost of the increased tuition or face bankruptcy and close its doors.

The proposed cuts in the financial aid programs threaten to produce just such a scenario. The budget cuts do not merely mean an increased burden for students, but instead point to the elimination of choice. Without choice there is no competition among sectors and institutions, and there are no incentives to keep costs down. Choice is not a luxury in American higher education, unless Congress intends higher education to become a luxury, available only to the rich. We do not believe this is your intent. We urge that this does not become an unfortunate outcome of your attempts to solve other pressing economic problems. Choice is an imperative of American higher education.

SPECIFIC CONCERNS

It makes it difficult to even begin to look with an objective view at the Administration's proposed financial aid cuts when their support of tuition tax credits and the elimimation of student social security benefits bring to light gross inconsistencies.

Perhaps the most inconsistent portion of the Administration's proposals for financial aid cuts concerns the treatment of student social security benefits and tuition tax credits. The Administration's proposal indirectly contends that student social security benefits are a form of Pell Grants, and therefore should be considered in the same manner as parental and student contributions. While we agree that something must be done to correct occasional "overawarding" we fail to comprehend the logic behind penalizing all recipients irrespective of their needs and circumstances. At the same time, these proposed reductions are based on the claim that this loss in aid can be recovered through current financial aid programs, which obviously cannot be done because they are also being cut.

It is equally incomprehensible that the Administration can consider a 4-6 billion dollar tuition tax credit bill, while at the same time call for cuts in the existing programs because they are "too expensive".

PELL GRANTS

The status of Pell Grants as the "cornerstone" of financial aid is seriously challenged by the Administration's proposed budget cuts. Current figures available from the Congressional Budget Office suggest that students face a very gloomy financial future if they attend to go to college this Fall. It is bad enough that education costs have been rising as financial aid has been declining (today, an $1,800 Pell Grant is worth only $1,350 in FY 79 constant dollars and will meet less than 45% of the average college cost) but now, shortfalls for FY 81 in the higher education appropriation threaten to seriously jeopardize a student's ability to enter college.

At this time, the appropriation for Pell Grants is approximately $1.4 billion short of funding the program at last year's level. The Administration has proposed a supplemental of $661 million assuming a $1,750 maximum award with the assumption that their proposed cuts will be passed. Unfortunately however, even if these proposals are passed, the Administration's proposed supplemental is still far short of funding a $1,750 maximum award. Thus, this additional shortfall will cause a double cut for students, particularly those students at independent institutions.

The first cut, involves the Administration's proposed change in the family size offsets, which by itself causes two adverse consequences. By not adjusting the family size offsets for inflation, the Administration is requiring low income families to pay more from a smaller income base than it does from a middle-income family who has to make up less of a dollar reduction from a larger income base. The second adverse effect has occured as a consequence of this proposal. By ordering the proposed change in the form of a regulation, the Administration has unnecessarily temporarily halted the processing of Pell Grants. This delay threatens to pull the rug out from under students by violating the purpose of the foward funding concept. This concept was designed to enable students and institutions to plan a year in advance. However, as funds remain intact over the course of an appropriations process they become very attractive targets for larger cuts. This new delay, threatens to withdraw expected financial aid after this academic year, thus making it impossible for institutions to notify students in the Spring of their Fall awards.

This delay is totally unnecessary. If Congress feels that they must cut the program, the current system contains a mechanism known as ratable reduction which allows for the same levels of cuts as the administration has proposed without delaying the processing of Pell Grants.

The second cut, will occur after the first series of proposed cuts still produce large shortfalls for a $1,750 maximum award. If ratable reduction is to be used again to make up these "new" shortfalls, students at independent institutions will be disproportionately affected.

It is apparent to us, that in an effort to force the Congress to act immediately without the chance to further analyze the impact of the proposed cuts, the Administration is using students as political pawns.

Therefore, the Coalition strongly recommends the following:

1. We urge Congress to immediately defeat the proposed regulation which changes the current family contribution schedule by not adjusting for inflation. This will

turn the Pell Grant delivery system back on and will prevent the chaos and trauma inherent in the Administration's proposal.

2. If Congress still feels they must cut the FY 81 Pell Grant program we urge you to use the current mechanism in the system that will both, cut the same amount as the Administration has recommended and assure minimal delays in the system. However, we strongly urge the Congress to alter the current ratable reduction formula to one that is more sensitive to the different sectors. We would be happy to work with the subcommittee to produce a more equitable reduction formula.

For FY 82, the Coalition recommends a $1,900 maximum Pell Grant award in order to retain students currently in the program, and to address the needs of low-income students. The average cost of an independent institution is increasing by an average of 15% this coming year, bringing the average cost of attendance to $7,500. The Coalition opposes the Administration's proposal to increase the tax rate on discretionary income from 14% to 20%. This proposal will have the effect of repealing the Middle Income Student Assistance Act, eliminating some 600,000 students from the program.

Supplemental Educational Opportunity Grants (SEOG)

Campus-based financial aid programs are of crucial importance to our constituency. While Pell Grants, with its income-based, national eligibility formula, is important in providing a foundation for access to some postsecondary education, it is the campus based programs alone which are sensitive to college costs as well as income; it is these programs which, therefore, help students select a particular education on the basis of an individual needs rather than financial need. Of these the SEOG program is perhaps the most important, particularly for students in high-cost public and independent colleges.

In any effort to help low and middle-income students meet the costs of higher educationd, it is vital to increase grant aid through the SEOG program.

Level funding of $370 million as the Administration requests fails to take into account the rate of inflation, the greater number of students needing assistance, the increase in the cost of college and the reduction in parental income in constant dollars.

The Coalition recommends that SEOG should be funded at $395 million for FY 82. We believe this to be a responsible recommendation, for it provides some of the unmet need created by insufficient Pell Grants to low and middle-income students attending high cost schools.

National Direct Student Loans (NDSL)

The Coalition is deeply concerned and distressed over the Administration's failure to provide a supplemental for the FY 81 NDSL in order to fund the program at last years level. This 38% reduction in the NDSL program threatens to eleminate awards to some 135,00 students with documented need. The rationale for such a proposal is far from obvious.

At a time when banks are substantially raising interest rates and reducing consumer credit, the Administration is proposing to have 135,000 needy students go out and get Guaranteed Student Loans. If banks do not lend to students (which has begun to happen) or if the student has already reached the maximum borrowing limit under the GSL program, then tnese students will have no other source of funding with which to attend college next Fall. If students are fortunate enough to find available loans, not only will / the students pay more money but, the special allowance paid by the government to the banks will force the government to pay substantially more than would be the case hasd those students received NDSL's. This proposed cut is inconsistent with the President's balanced budget concept and appears to be soley politically motivated.

In addition, we resent the Administration's claim that they are "increasing" NDSL funding for FY 82. They are merely putting back the funds that they cut in FY 81.

The Coalition recommends $300 million for federal capital contributions to the NDSL program. Thisis still far short of the institutional demand for which exceeds one billion dollars.

State Student Incentive Grants (SSIG)

SSIG is one of the most logically compelling programs of the Federal student assistance programs. Particularly as we are forced to recognize the limits of the Federal budget, it is imperative for us to encourage states to re-assume a large responsibility for the provision of educational opportunity to students. Yet as exciting and appealing as the SSIG is to us today, it is essentially an untried concept, given the meagre funding it has received.

The Coalition recommends a SSIG appropriation of $100 million for FY 82, a modest increase so as not to strain the budget, but also large enough to spark an expansion of the state role in financing higher education. We hope that you will pay close attention to SSIG in this and future years, for its potential to contribute to the achievement of equal educational opportunity has never been so important.

Guaranteed Student Loan program (GSL)

While we applaud the Administration's efforts to improve the economy, it appears to us that the GSL recommendations are being made on popular myths and assumptions without any evidence to support these allegations.

A large portion of the growth in the GSL can be attributed to the removal of the income cap in 1978 with the passage of MISAA which resulted in increased demand for these monies. However, it is not primarily this demand which has quadrupled the cost of the program to the Federal Government, it is the sky-rocketing interest rates and the high cost of money, to which the program is tied.

The following chart illustrates how the special allowance (The Federal money paid to banks) has quadrupled compared to the increase in the amount of money paid for the student's in-school interest subisdy.

* Guaranteed Student Loan Subsidy Costs
(millions of dollars)

	1977	1978	1979	1980	1981
In-School Interest subsidy	$225	$249	$296	$445	$655
Special Allowance	106	195	401	820	1,460
Average annual 91-day Treasury bill rate (%)	5.0	6.8	9.6	11.6	14.2

* Congressional Research Service February 20, 1981

In addition, contrary to statements which have received great publicity around the country, STUDENTS ARE NOT IN HIGH DEFAULT IN THIS LOAN PROGRAM. The estimated default rate for 1981 is approximately 8.8% compared to last year's 9.4%. To place it in perspective,you should note that this default rate is below the national average of defaults on consumer type loans.

Taking all things into consideration, the real culprit of the GSL program is the economy, not students.

The lack of current data makes it extremely difficult to propose drastic alterations of this program. It is surprising that the Administration seems willing for the students of this country to suffer the consequences of its action--which we believe are being taken without proper information.

The Coalition recognizes that sacrifices need to be made. But first let us realistically examine what changes would preserve both the health of postsecondary education and that of the economy. We believe that the Administration's proposals will not effectively do either.

College Work-Study (CWS)

The Coalition recommends a CWS appropriation of $600 million in FY 82. College work-studyis unique in its universal popularity among Congress, students, and college administrators. It is valluable in its assistance to students who may not be eligible for other forms of student aid-- particularly in higher priced colleges: over one-quarter of all aided students in higher priced (2000) colleges received CWS without BEOG or SEOG assistance. Its value is manyfold. CWS often provides students with a work experience relevant to their academic or professional interests. And it is a fiscal bargain, for at least 20% of CWS aid is derived from non-federal sources-- a particularly important point in these times of all-too-tight budgets.

Thank you again for the opportunity to discuss our concerns. I hope that you will rely on the Coalition to provide an independent college student perspective on these important issues.

STATEMENT OF DAWN SOLARI, STUDENT, NEW YORK UNIVERSITY

My name is Dawn Solari and I am presently a Junior at New York University. I am a politics major, following a pre-law curriculum.

To begin my testimony, I would like to briefly tell you about my background in order to impress upon you the necessity of financial aid for my education.

In 1970, my father deserted my mother and I. His whereabouts have been unknown ever since. Subsequently, three years later, my mother passed away and I have been residing with my sister and her two children for the past eight years. At the present time, my only means of support is a $270 monthly check from my mother's Social Security benefits. This check provides me with clothing, dormitory fees and any other bare necessities. As a result of my situation, I have become totally dependent upon state and federal aid for my education.

For the academic year 1980-81, I received $1600 from the Tuition Assistance Program (T.A.P.), $1750 from a Pell Grant (formerly known as the Basic Educational Opportunity Grant), and $2070 in New York University aid, $500 of which is a Supplementary Education Opportunity Grant and $1570 of which is a scholarship.

Now, I am faced with cutbacks in my Social Security benefits due to President Reagan's budget proposals. In addition, I am fearful that I will not be able to complete my education due to the proposed cuts in aid programs.

Ever since I was in high school, I have yearned to become an attorney. When the time came to apply to college, I wanted to attend a renowed, prestigious university in order to receive an adequate liberal arts education. However, I could notsimply choose any university that accepted me. My choice was limited to the college that provided the most aid.

I have been extremely fortunate thus far in regard to aid. New York University, as well as the state and federal government, have been very good to me. In turn, I have put the aid to good use by trying to get the most out of my educational experience. I have been successful in my academics and I have been a student leader for the past three years as well as a member of the Independent Student Coalition since the beginning of this semester. In addition, I maintained a full-time summer job with a legal firm in my home town and have continued on a part-time basis during the academic year. I would like to continue my attempt in achieving my goals but unfortunately the future looks very dismal. After working very hard, I might be denied the basic right to complete my education - an aspect of my life that has always been very important to me.

I have already witnessed the $200 reduction in my tuition assistance award for no apparent reason other than the fact that I am an upperclassman and it is assumed that I will receive more money from summer employment. However, my tuition as well as the cost of living has been increasing every year and therefore I honestly cannot accept this rationale as valid.

In conclusion, I would like to express my sincere gratitude for allowing me to testify today. I come here,most importantly, as a representative of my fellow students from the largest private university in the state. Many other students are expewriencing the same fears as I in regard to not being able to return to New York University in the fall. In addition, there are thousands of high school seniors who will be denied the chance to attend the university. I have come as a spokesperson to ask all of you not to allow this devastation to occur.

STATEMENT OF BILL LASH, STUDENT, YALE UNIVERSITY

Mister Chairman,members of the subcommittee. Thank you for allowing me to speak to you today. My name is Bill Lash and I am a junior at Yale university,New Haven Connecticut, and I am chairman of the Connecticut Independent Student Coalition,an affiliate of COPUS.

I speak to younow,not as chairman of a coalition, but as an individual student,dependent on federal financial aid programs for my pursuit of an education. The same programs that the present administration proposes to cut.

I am one of two children of working parents,my father is a postal worker, and my mother is a nurse. I have an older sister,a senior at Lafayette College, who is planning on going to medical school. Our combined educational costs this year were over 18,000 dollars , a figure that represents nearly 40% of my families total income. There is no way that we could pay for our educations without federal financial aid.

Costs at Yale this past year were in excess of ten thousand dollars. I receive a$2,794 scholarship from Yale. This leaves 72%,over seven thousand dollars left to be paid. My parents are forced to borrow from banks and credit unions to pay their $ 2,500 parental contribution to Yale and another three thousand dollars to Lafayette.

My financial need after I pay $950 of my $1300 summer earnings directly to Yale, is $6570. This comes from federal and state financial aid programs. My state of New Jersey scholarship of $100, covers less that 1% of my costs. The remaining need is covered by Pell grants,supplemental Educational Opportunity grants(SEOG) and Guaranteed student loans. I receive a $226 Pell grant,a $750 SEOG and a $2,500 GSL. I was previously receiving a National DIrect Student Loan,(NDSL) but was forced from the program due to eligibility requirements.
My New Jersey scholarship is in danger of being cut, and I will probably be forced out of that program as well.

I have not neglected to help myself. During the academic year I hold three jobs. I am a researcher-clerk, American Express agent and a bartender. My sister has done the same, working as a dormmitory guard, botany teacher and waitress. We normally work during our spring,winter and summer vacations, and have done all of this while carrying full course loads and maintaining B plus grades.

The proposed cuts to the Pell grants and GSL programs would force me to leave Yale,one year away from graduating. The return to pre-Middle Income Student Assistance Act(MISAA) levels of eligibility will make me ineligible for these forms of financial aid,because a computer has said that my family income is too high. The Middle class student attending an independent institution will be caught in a Catch-22 type of bind. He will be unable to afford to attend the college that he has chosen due to a lack of money,but he finds his family makes too much money to qualify him for the aid he needs to attend the college he can not afford.

Enrollment at our independent institutions will,shrink while the numbers at the state colleges well swell and become unmanegeable. Many smaller private colleges will be forced to close their doors and will cease to operate. Larger, more famous institutions like Yale will still be open,but with a large difference in their student population. The child of the doctor,the banker and the corporate executive will still be there, but what becomes of the bus drivers' daughter,the mechanics son and the children of the postman? They will be forced to dissapear from the expensive ,private campuses, which once again will become the exclusive domain of only the very rich. They will return to the already over-crowded state universities or perhaps to the marketplace or the farm. Equal access to education will become but a fond memory. These cuts will bring the death of diversity on campus. The elimination of the in school-interest subsidy poses still another problem to the educational and career plans of thousands of students. If a student were to borrow a GSL at current rates with no in school interest subsidy, he would become so deeply indebted that he would be forced to accept the most lucrative job offer he received and not the one he truly wanted. I plan to become a lawyer. The decision of whether to practice in the slums of Harlem or in a WallStreet skyscraper would not be made by me, but by my friendly neighborhood banker. Vital but low paying jobs such as the Peace Corps or Legal Aid worker would go unfilled , while competition on the corporate ladder grew hotter still.

These programs must be maintained for the thousands of students and families that depend on them. When you cut an education budget,you are not cutting mere dollars and cents. You are slashing human lives,careers and dreams.

The thousands of students like myself who depend upon these vital programs must be given the same opportunity for an education as the children of the wealthy.

I urge Congress to fund these programs at existing levels without any cuts.

Once again, I thank you for allowing me to voice my concerns.

STATEMENT OF EDUARDO WOLLE

Mr. Chairman and members of the Subcommittee, I would like to thank you, on behalf of the 3.5 million college and university students USSA represents and the more than 7 million college and university students across the country who depend on some type of financial assistance to get them through college, for the opportunity to testify on the proposed FY'82 appropriations.

USSA is concerned with the impact of the proposed Administration's budget reductions and FY'82 budget requests and the effect these recommendations will have on the cost, quality and access to postsecondary education across the nation. Should the Administration's requests pass, we will see a high drop-out rate, unemployment and increase in tuition. Even if the Administration means well, the results may be disasrous.

We as students, are concerned with the possibility that if Congress accepts the Administration's budget proposals, all the advances that have been made in meeting the needs of the middle class through MISAA, in providing easier access to college for lower income students, in stablizing the loan programs and in allowing a healthy competition between the public and private sector to develop will have been an exercise in futility. There are many advantages to living in this society that are not available to other people throughout the world. However, when other countries are giving their people a chance to receive a fully subsidized postsecondary education, this government is retreating on its commitment to provide access to all of its citizens. How can a nation expect to be number one in anything if its working masses buy into the system yet are told that their investment is being cut and their return will be minimal? How much more can the poor be expected to sacrafice when they are living in areas where unemployment is high? Can you look your constituents in the eyes and tell them "I'm sorry but we have to cut back on your child's opportunity to receive a higher education since we must balance the budget, substantially increase defense spending and invest over $30 billion for a race track nut shell missile game"? Congress must not loose sight of the programs they set up to aid students achieve the promises of our society. Students have been asked to bite the bullet for quite some time. We don't mind biting the bullet but if we have to bite it any harder, it will explode in our mouths!

The Pell Grant is presently under financed, without appropriate regulations, processing of forms have been halted and the program is slated for legislative changes. Furthermore, the NDSL program finds itself in similar financial difficulty. We find the precarious position in which both programs are balanced to be extremely dangerous.

Presently, the Pell Grant needs a supplemental of $1.2 billion (according to CBO) to fund a maximum award of $1800 (Continuing Resolution requests $1800). The NDSL program needs a supplemental appropriation of $100 million to restore the program to the FY'80 level of $286 million.

The Administration requests a supplemental for Pell Grants of $661 million for a $1750 maximum. This figure assumes that proposed legislative changes will pass Congress and that Administration calculations are correct. However, should Congress not adopt one or all of the Administrations proposed legislative changes, there would be a tremendous shortfall in the program. Yet, if Congress does adopt the legislative changes and the $661 million supplemental, the results would still mean students being cut from the program and shortfalls in needed monies, for example, 250,000 newly eligible students would be displaced from the Social Security benefits program into Pell Grants. Furthermore, the Administration requests no supplemental for NDSL in FY'81. If needed monies are not restored to this program, approximately 135,000 students may loose their chance for a college education.

ACE has already expressed a concern we all share: that to delay this decision on needed monies until late spring or summer will result in the disruption of 5,000,000 students plans to attend college.

USSA supports funding the Pell Grant program at a $1900 maximum award level for FY'82. The Administration recommends an award level of $1800 for FY'82, the same level as 1979. However, 600,000 students will have been eliminated from this program because of proposed legislative changes by FY'82.

This program is the cornerstone of the financial aid package. Imposing a $750 self-help requirement, as proposed by the Administration, before calculating the student's first award would be unacceptable since the majority of higher education institutions have unrealistic student financial aid budgets. For example, the areas within a student expense budget which tends to vary from institution to institution include personal expenses, off campus housing, transportation allowance and food costs. Those students that would be hurt would come from an income range of between $8,000 and $15,000 and would include independent students.

A $1900 award is still below the recommended $2100 maximum which Congress voted for in the Higher Education Amendments of 1980. If Basic Grants had kept pace with inflation, grant awards would have tripled.

USSA recommends funding the SEOG Program at $400 million. However, funding at $400 million could cause a shift in allocations to schools . We further advise the subcommittee to commission an analysis of this situation before taking action on needed appropriations.

In any effort to help low- and middle-income students meet college costs of higher education, it is vital to increase grant aid through the Supplemental Educational Opportunity Grants, particularly for students attending higher priced institutions. The existing level of SEOG funding is insufficient. The unmet need at many private and public institutions is great and often means an institution must often help students by supplementary BEOG and SEOG support out of their own limited funds. But institutional resources are already overextended, state student aid is unevenly distributed, and students attending college outside of their home states are usually not eligible for state aid.

USSA supports funding SSIG at $100 million which is the maximum under current law. This program, which requires states to match federal dollars, has been highly successful in stimulating states to establish and expand their state grant program. This is a true partnership program between a state and the federal government.

USSA urges funding for CWSP at $600 million. This is below the recommended $720 million maximum in current law. College Work-Study is a unique program providing a self-help mechanism for financing higher education for low and middle income students and graduate students without increasing students' debt and providing work experience which is itself part of the educational process. With the high unemployment among teenage youth, it is extremely important to make employment opportunities to provide jobs for students. CWS is also a vital program for graduate students. In 1976-1977, 35,000 graduate students were assisted by this program. This recommended amount of funding could provide as much as 60,000 additional jobs for students, both graduate and undergraduate.

USSA recommends funding the NDSL program at $300 million, which would be below the current law maximum of $400 million. Approximately 800,000 students are assisted annually by this program, over half of which come from families with incomes less than $12,000. The NDSL program has increasingly functioned as a back-up to the Guaranteed Student Loan Program by making loans to students not able to get them from the private money market. In 1976-1977, more NDSL's were made to college students than GSL's, and a greater proportion went to low income students. Eight percent of the NDSL recipients in 1976-1977 were graduate students who depend on loans and work to finance their education. The NDSL program has such a large percent of low income students since banks are generally willing to lend primarily to students from families which have good credit and, in the face of their policies, to make only a certain number of student loans, tend to select students who are the safest credit risks, and who are residents of the state and attending college in the state in which the bank is located. Thus, it is imperative that a supplemental appropriation be made for FY'81 or those which the President has said he wishes to protect will not be able to return to college.

USSA advises an appropriations for the GSL program of $3.474 billion for FY'82. This figure is based on CBO estimates which may be subject to change. We caution this subcommittee not to lock itself into figures proposed by the Reagan Administration. Administration figures assume a drop in interest rates. In determining allocations for GSL's the subcommittee must be realistic. If the subcommittee assumes funding for GSL based on a T-bill rate of 8% but that rate only declines to 11%, a supplemental will be needed for the GSLP. This will repeat problems already experienced in other education programs, i.e. Pell Grants, NDSL.

The Administration recommends two steps in cutting costs for the GSLP, eliminating the interest subsidy and requiring a needs test. The CBO estimates that should the interest subsidy be eliminated, 25% of those students in the GSLP would drop out. CBO also estimates that if a needs test were part of the requirements for a GSL, 50% of those in the program would be eliminated. This would tend to force loans on low-income and lower-middle income students. Our idea of disadvantaged students receiving high interest loans along with a low interest loan and other aid, with $750 self-help, is not mortgaging that student so that he/she will default because of high repayment.

An example of what a student would pay now and under the Administration's plan:

$7,500	9% interest with in-school interest subsidy 10 year repayment- $11,000
$7,500	9-12% interest with no subsidy - $13,000 - $14,000

Another group which would be adversely affected are graduate students. Asking students to pay significantly higher levels of interest is creating a generation of indentured servants who are mentally mortgaged to the government.

USSA advocates appropriations of $200 million for TRIO. This is below the current law maximum recommendation of $400 million for FY'82. I would like to request that testimony by Michelle Thomas, TRIO Desk Director, and a letter by Dean Hal Payne, Oberlin University be entered into the record as they will address the needs of the TRIO program.

Thank you.

STATEMENT OF DR. G. WAYNE BROWN

Mr. Chairman, I am Wayne Brown, Executive Director of the Tennessee Higher Education Commission (THEC), the statewide higher education coordinating agency. I wish to thank you for affording me the opportunity to present this testimony on behalf of the Tennessee Higher Education Commission, and for my fellow state chief higher education officials, represented by the State Higher Education Executive Officers Association (SHEEO).

Let me emphasize from the outset that we in Tennessee certainly appreciate the magnitude of the problems that surround this nation's economy. We cannot disagree with the importance of controlling federal spending and particularly of reducing unnecessary expenditures and waste. We even concede that in bringing the federal budget under control we in higher education, and in state government, must be willing to shoulder our due share of the burden.

I am concerned, however, that the programs proposed for reducing federal expenditures in the higher education sector, and particularly for student financial assistance, represents a dislocating action. I can best explain this position from my perspective as head of Tennessee's higher education coordinating agency, but I know my thoughts represent those of virtually all of my fellow SHEEO members.

Well over $100-million in federal student financial assistance will be utilized by Tennessee students this academic year. Twenty three thousand students received Pell Grants, 18,000 guaranteed student loans, and 14,000 social security education benefits. This was money that was not expended frivolously: it was used to acquire the learning and skills these men and women need to become productive citizens of our state and nation. It is also money that very substantially supports Tennessee's colleges and universities, both public and independent.

This last point is, I believe, very often overlooked in the debate over student financial assistance policies. Somehow, sight has been lost of the purpose of this assistance: to enable students to acquire a higher education, and to have the resources to pursue that education. Tennessee, like every other state, provides substantial support to higher education. This year, as in the past, approximately 17% of the Tennessee budget has been dedicated to the support of our colleges and universities. But while the slice of the pie has remained about constant in our state, the pie itself has been shrinking. This year our state institutions had to absorb a $13.6 million impoundment in their operating budgets, and, for FY 81-82, we anticipate a further erosion in real dollar support for higher education. As a result of these mandated reductions -- mandated by the same economic conditions that have caused the President to demand his cutbacks--student tuition and fees have risen in four years from 21% of the total income of our state institutions to nearly 28%. I hear a lot of talk about "self-help", of paying full value for services. We have long ago been forced to practice that theory. This year, for example, we propose increases in tuition at our state colleges by 18%, with a doubling of tuition for our medical students. We have not made these increases because we want to increase the burden imposed on our students and their parents and spouses. But we have not had any choice, as we have watched our state tax revenues dwindle and our mandated costs increase.

This introduction to the economics of Tennessee higher education leads me to the focal point of my testimony: federal support for higher education cannot be suddenly and sharply decreased without transferring a large burden to the states. This Administration has spent a great deal of time and effort proposing a return to the federal-state partnership, or a restoration of balance to the federal system. As a native of what I can proudly declare to be among the most fiercely independent states of the Union, I can only applaud such an approach. But the Congress must understand that it would not be restoring to the states that which is rightfully our own. Rather, it would be denying us-- as political entities as well as aggregations of citizens -- of the resources necessary to enable us to provide the level of services our people need.

Let me now address specific elements of the Administration's student financial assistance proposals, again from my vantage point as a state chief higher education officer.

Pell Grants

First and foremost, we are deeply concerned over the delay that has arisen in the initial processing of Pell Grant applications. I understand that nearly a million and a half application forms are backlogged at the processing center in California, with no indication when work will resume on them. This delay -- occasioned by the withdrawal of the regulations promulgated in final form on the 19th of January of this year -- is creating an air of uncertainty among our students and their families that is beginning to have a very negative effect. Our institutions cannot begin to package their campus based aid without having the Pell Grant information available to them. Students cannot seek loans for their residual need without such information. And we cannot forecast demands on state revenues without knowing enrollment and student assistance figures. It is my understanding that there is a serious legal question whether the January 19th regulations may be withdrawn, given the clear Congressional mandate to promulgate these regulations on a fixed schedule. I urge the Congress to require the Department of Education to immediately proceed with processing Pell Grant applications on the known basis of the January 19th regulations, instead of seeking further delay to revise the current program.

We understand the need to hold down the costs of this -- as every other -- program. But we also believe that the approach currently proposed is inappropriate because of the delay and uncertainty it will cause and the inequity of its effects. We have reviewed the proposal prepared by the National Association of Student Financial Aid Administrators (NASFAA) for FY 81 Pell Grant funding, and we find them to represent a very reasonable approach that takes into account the savings requested by the President. Most important, they could be implemented with no further delay in processing Pell Grant applications. I urge your approval of this solution, instead of the far more time consuming approach proposed by the Administration.

Our Association is working with other higher education groups to develop an alternative proposal for FY 82 and beyond. As a point of departure, we consider the NASFAA proposals worthy of very serious consideration. We do believe, however, that consideration should be given to raising the permissible minimum award, from the present level of $200 instead of reducing the maximum award which goes to the most needy students. Finally, I must again stress the need for swift action to get the Pell Grant program moving again. If the specific proposals made by NASFAA for the current year are not sufficient in terms of reducing expenditures, then we believe it far more equitable to implement the ratable reduction procedures established under the law rather than to attempt the ad hoc corrections currently proposed.

I must close my discussion of the Pell Grant program by taking note of what appears to be a very serious shortfall in funding for the current year's program. The Administration's proposal for a $661-million supplemental appropriation is inadequate to meet the diminished expenditure levels the Department predicts. Congressional Budget Office estimates, and those of such groups as NASFAA, put the need at closer to $1-billion. We urge the Congress to consider carefully the need to support this baseline -- to use the Administration's term, safety net -- program as a level that would assure its effectiveness.

Guaranteed Student Loans

The Guaranteed Student Loan program has been a major factor in enabling many moderate income families the opportunity to afford their children and spouses access to higher education. At the same time, the structure of the program, particularly since 1978, has without doubt caused its costs to increase far beyond expectations. From my vantage point, however, this cost escalation has not substantially resulted from students without need taking advantage of the program. Sharply rising interest rates coupled with a general inflation that has dramatically increased costs of attendance has created a demand for loan assistance beyond the contemplation of the institutions and lending agencies, as well as that of the Congress.

The solution to this problem, however, is not to impose harsh limitations on the program, driving away those students who need and merit this assistance and possibly causing the complete collapse of the loan structure. The Administration proposals to apply a strict needs test to establish eligibility and to eliminate the in-school interest subsidy would have this effect.

We have carefully considered the effects of these proposed changes on Tennessee students. I can say in all honesty that the recommendations of the Administration would drive out many of the lenders we have personally labored to bring into participation. They would impose an enormous administrative burden upon our institutions at just the time we are trying to decrease costs. Our own Tennessee Student Assistance Corporation, of which I have the pleasure to serve as vice-chairman, would be thrown into disarray.

We urge instead that a Family Loan Income Eligibility Index be established, perhaps at an adjusted gross income level of $30,000 for a family of four. Below this index level, a student could borrow, as is now the case, the difference between his or her cost of attendance and other forms of student aid. Above the index level, a student would still have access to the GSL program *if* he or she could demonstrate actual need. Such an approach would eliminate a needs test requirement for the vast majority of GSL applicants, and therefore substantially reduce the burden on the institutions and the lenders. I believe the resourcefullness of this approach is clear: there can be no question that a family of four with an adjusted gross income of $30,000 merits assistance, if only in the form of a subsidized interest rate, to cope with costs of attendance in excess of $4,000 at even a low-cost public institution.

As vice-chairman of the Tennessee Student Assistance Corporation, I am particularly concerned over proposals to eliminate the in-school interest subsidy. We have spoken to many lending institutions about this proposal, and they are unanimous in their opposition. The administrative burdens that would be imposed by attempting to collect the interest while the student is in school are impossible to bear, and the alternative, of adding the accrued interest to the loan amount upon graduation, would so inflate the indebtedness as to vastly increase defaults. In the opinion of my banker friends, the net result would likely be a loss to the Treasury.

My colleagues in SHEEO have reviewed the NASFAA proposals to improve the Guaranteed Student Loan Program. As in the case of Pell Grants, we are pleased to be in substantial agreement with the principles set forth in that proposal. We are working on our own further analysis and proposal, which we will convey to this committee and to other cognizant bodies in the very near future.

National Direct Student Loan Program

I must touch briefly on a very specific problem of this program. The Administration proposes a supplemental for this year to increase NDSL funding by $100-million. But that would only bring the program up to last year's level, and I understand that this would result in a further very substantial shortfall in allocations. Because of the hold harmless provisions of the statute, the allocation among the states would be extremely inequitable, and I urge you to examine this problem with great care.

Educational Outreach

I recognize that I have been invited to discuss student financial assistance issues. However, in my role as executive director of the Tennessee Higher Education Commission I must call to your attention the damage that would be done to our capacity to improve the efficiency of higher education in our state without Title I support. The new Title I-B combines the programs previously separated as Continuing Education and Public Service, Educational Information Centers and Statewide Coordination and Planning into one omnibus program. Although the law provides for a certain proportional distribution of appropriated funds for each of these purposes, the new Title I-B affords my state great latitude in determining how best to expend this important resource for the purposes of educational outreach, information and coordination.

Indeed, in a very real sense Title I-B is a good example of a higher education block grant program. Our state is free to use the funds, within certain guidelines, as it deems fit, and to employ the services of all sectors of the state to carry out these purposes. Without these funds many of the important things we are doing to reach those citizens who need higher education services, to inform them of their options, and to coordinate our delivery of those services would be lost.

The new Educational Outreach title is not a giveaway: it is a very wise investment that in my view maximizes the return for the other forms of federal higher education assistance, particularly student aid. I strongly urge that the **rescission** request be denied, and that funding for this program be continued in the next fiscal year.

STATEMENT OF WILLIAM L. GEORGE, S.J., GEORGETOWN UNIVERSITY

Senator BURDICK. Higher and continuing education, the next subject of the panel.

The panel will now be heard from and they can introduce themselves as they speak.

Father GEORGE. I am Father William George, special assistant for the president of Georgetown University, and I would like to submit my testimony for the record, which concerns mostly higher education facilities, and since I am in town I can come to the Congress and speak to people and I would like to offer my time to the American Council on Education which will have a more verbal type of presentation on their part of the problems.

May I do that?

Senator BURDICK. Well, that is very nice of you. [Laughter.]

STATEMENT OF RICHARD J. SMITH, NATIONAL STEERING COMMITTEE, ADULT EXTENDED LEARNING SERVICES

Mr. SMITH. Mr. Chairman, I am Richard Smith from the State of Michigan and I am chairman of the National Steering Committee of title I-B of the State education act.

The State administrators are looking very, very strongly at the October 1980 signing of the Education Amendments of 1980.

The Congress should be commended for looking particularly at the needs of the unserved and underserved in this title I-B continuing education outreach program. As we look at the unserved and underserved, we have had a 14-year history under the Higher Education Act of a State-based program that has focused on understanding better and implementing programs with the underserved. This includes the rurally isolated, those that are elderly and also those people who particulary reside in communities and are trying to understand what their destinies look like when they and their families are looking at unemployment, underemployment, and such.

Title I-B, as we see it, is the only Federal postsecondary program solely and exclusively designed to counteract the effects of equal access and equal opportunity. As we know, the demographics in our Nation as far as who is accessing postsecondary education is becoming an older adult population. As we really take a good look at who these older adults look like, usually the affluent, usually those who have means comparable to others and the Congress program enacted back in October 1, 1980, again focuses very, very intently on those unserved and underserved in an extended outreach activity.

Within title I–B, it brings together for the first time planning bodies, educational information centers and continuing education people.

The beauty of this new legislation that we are anxiously awaiting to work on is that it unites more effectively business, industry, Government, labor, aging constituencies and aging folks.

So consequently we are recommending, Mr. Burdick, that the Senate subcommittee deny the executive fiscal year 1981 rescission request for title I–B and at the same time move the $15 million appropriation so that we could move 700 projects designed by these very people who have had barriers put in front of them in terms of their adult earning needs.

At the same time we request a $25 million appropriation for the fiscal year 1982 title I–B program. We want to move it. We are ready to move on the congressional program for title I.

STATEMENT OF CHARLES TAYLOR, PRESIDENT, WILBERFORCE UNIVERSITY, UNITED NEGRO COLLEGE FUND, INC.

Dr. TAYLOR. Senator Burdick, I am Dr. Charles Taylor, president of Wilberforce University, Wilberforce, Ohio. I am speaking today on behalf of the United Negro College Fund.

We are deeply appreciative for this opportunity to appear here today and to share with you some of our concerns regarding pending legislation and proposals for rescission.

First, I would add that while there is much to be concerned about in a negative way, we in the United Negro College Fund at least are encouraged with respect to the increase in title III funds which we believe is a clear indication of the administration's recognition of the tremendous resource that resides in the Nation's developing institutions. And we are appreciative of the support that the administration has indicated for those programs.

We also share the administration's concern with respect to the need for balancing the Federal budget and to bring inflation in line. However, we are concerned with what must be a pressing problem in this point in time in terms of how these programs will affect the truly needy or the neediest students as it has been called.

First, we are concerned about who the administration has reference to with respect to the truly needy students. We have been unable to find clear definitions of to whom that category refers to. And we are hopeful that some definitive description can come forward so we will know exactly what groups of students we are talking about.

Regardless of whom or which students are included in that category at present, we are concerned about the proposals for the change in the regulations at this point in time which are suggesting to us that history may repeat itself and in fact be worse than it was in 1978 when the processing of the basic grants program was shut down and there was a tremendous backlog of student applications. Within the United Negro College Fund, during the year that backlog occurred, we saw more than a 20-pecent reduction in student enrollment during that time, and we are concerned that this process be speeded up and perhaps these regulations and proposed change of the regulations be put off until the next fiscal year and then we will proceed as scheduled during the current period so that all of this processing can get taken place.

We are also concerned about the $750 student self-help provision. Most of our students come from families with an annual income of less than $8,000. As you know, there is in many States over 60-percent unemployment among young black teenagers and it is going to be extremely difficult, in most instances impossible, for young black students who are attempting to come to our institutions to meet such a requirement. If they were able to meet that requirement their need would not be so dire in the first place.

So we are deeply concerned about that and would suggest that some other provision for making those reductions as needed would be addressed.

We think that if equal access to higher education and to securing of that equal opportunity, particulary for the truly needy student, is to be maintained, we have to open up and move this process forward immediately or there are going to be literally thousands of the truly needy students who are not going to have access to higher education this fall simply because the processing won't be done or they won't be able to meet some of the requirements that have now been suggested in the new regulations.

We thank you for this opportunity, Mr. Burdick, and we will be happy to respond to other questions that are included in our statement that we have submitted for the record.

Senator BURDICK. Title I has had a history of serving adults who have not had access to education in the past. If your Federal funds are cut, do you see the State or local governments or other institutions picking up the cost of title I programs?

Dr. TAYLOR. The problem with shifting the responsbility is that the Federal Government has been the principal advocate and protector of equal opportunity for minority students, minority population. To shift this responsibility now away from the Federal Government I think takes away much of the momentum that has been built up, and rightly so, over the years.

This is not to suggest that there are not responsible people at the State level. What it is to suggest is that the momentum that was built in the first place was there for a purpose.

So there is considerable uncertainty about what the result of such a move would be and we would encourage a reconsideration of such a move.

Senator BURDICK. At this point the able Senator from South Dakota, my neighbor to the south, Senator Abdnor, will take over the responsibility of the Chair, and, Senator Abdnor, I recommend that you find the time—out of the kindness of Father George—he gave up his time. You may want to have 1 minute or 2 after a while.

Senator ABDNOR. This is what is called substitution time. Please proceed.

STATEMENT OF SANDRA TIMMERMANN, INSTITUTE OF LIFETIME LEARNING, NATIONAL RETIRED TEACHERS ASSOCIATION

Ms. TIMMERMANN. I am Sandra Timmermann, head of the Institute of Lifetime Learning of the National Retired Teachers Assocation and the American Association of Retired Persons.

Like my colleagues I am also here today to testify to title I of the Higher Education Act. More specifically, I urge you not to accept the proposed rescission of fiscal year 1981 funds for title I and that you appropriate $20 million for fiscal 1982.

NRTA-AARP is supported by a number of organizations, and with your permission I will submit a list for the record along with our full statement.

Senator BURDICK. We will be happy to include it as part of the record.

Ms. TIMMERMANN. The case can be simply stated. First, in 1980 the Congress sharply focused it so that its primary agenda is to improve access to postsecondary education for adults, particulary those who have been underserved previously, such as older persons, the unemployed and underemployed, the rurally isolated and others facing significant barriers to postsecondary opportunities.

I would like to mention just two programs as illustrations to give you a better idea of what I am talking about.

One was a 10-week program of courses in career planning in science, mathematics, and study skills for women who have been out of formal education but who now need to return to the labor market for economic reasons.

Another is educational program for older workers to improve their working life prior to retirement and to help them plan for economic stability after retirement.

A second point, title I underwent another significant improvement in 1980 through consolidation of three previously separate but related programs. One was community service and continuing education. Another was an education information center and the third Statewide planning.

As a result, administration has been streamlined and the regulations have been reduced. Further, States have been given greater flexibility resulting in less paperwork and structural requirements.

A third point, rather than creating new structures, the refocused title I seeks to enhance access to existing programs and services, both within and outside the traditional education system, primarily where adults live and work.

In this way a relatively small amount of money goes a long way.

Fourth and finally, a loss of title I funds would not simply mean a loss of Federal dollars. It would also mean loss of leverage title I provides in the releasing of additional moneys at State level but within the private sector.

In summary, title I fosters educational, informational and support services which enable adults to gain postsecondary education necessary for employment, cope with family responsibilities and to remain independent and self-supporting.

We urge that the committee continue its support of this modest but important program.

Thank you very much.

Senator BURDICK. Thank you.

STATEMENT OF LAWRENCE S. ZAGLANICZYNY, ASSISTANT DIRECTOR FOR CONGRESSIONAL LIAISON, AMERICAN COUNCIL ON EDUCATION

Mr. ZAGLANICZYNY. I am Larry Zaglaniczyny, assistant director for congressional liaison for American Council on Education.

I am delighted to be here today and may I, with your permission, submit a supplemental statement to our original statement that covers the other higher education programs.

I wish to concentrate today on student aid. I maybe should have been on the prior panel. But here I am nonetheless.

I also would like to submit a statement for the record on the mining fellowship program.

Senator BURDICK. Without objection both statements will be included in the record.

Mr. ZAGLANICZYNY. As the last panel on student aid indicated, we are faced with a problem in the supplemental and we strongly support strong action on the supplemental both for the basic grant program, which I think you may know has been shut down.

We do find that 5 million students are faced with waiting to find out if they have a grant and what the amount of the grant will be. That makes their college-going plans a questionable exercise if one doesn't know if one will have student financial aid to attend college in the next year.

We urge quick action on the supplemental for the basic grant program and we will be working with the administration and Congress to try to get the program back to speed and the processing continuing.

We also support a $1 million supplemental for the national direct student loan program for fiscal year 1981. The administration has recommended an additional $100 million fiscal year 1982. The problem we have here is that while this 1-year drop of $100 million will perhaps save some money in the long run, it impacts the States in a very harmful way. And if I also may submit for the record a State-by-State breakdown of the percentage and the dollar amounts that would be lost in this 1-year stoppage, your State, South Dakota, would only get 53 percent of the funds that they received in the prior year. So it would attach onto the supplemental.

For fiscal year 1982 we support in the categorical programs the President's request where he has increases and we support level funding for all of the other programs. We will be taking an inflation hit there but those programs are important for very specific needs.

In the student aid area we have pared down our recommendations to the absolute bone. We do recommend increases. We will be willing to work with the staff especially in the basic grant program where we recommended an increase of a maximum basic grant from $1,800 to $1,900. We think we can do that by shaving some other parts of the program and do it for just a little bit more than the Reagan administration proposes in terms of total dollars.

We in the basic grant program—as you may know, that maximum has not been increased since fiscal year 1979 and college costs have gone up approximately 30 percent in that period and the students very desperately need the increase in basic grants.

And finally, I noticed in today's Washington Post an editorial about struggling with student loans and we all always struggle with student loans, too. I think it accurate describes the situation in terms of basic grant programs and how that has been stopped.

I do think, however, the Post does a disservice to its readers, and I really wish to get this on the record, when they gave the example of the parents taking a student loan and putting it into a money market fund. I will quote.

> If parents have the money on hand to pay college bills, they can take out a loan at 9 percent and redeposit the money in, say, a moneymarket fund at 14 percent.

I am not denying that may happen, but I do want to point out that that is illegal.

> Any person who knowingly and willfully embezzles, misapplies, steals or obtains by fraud, false statement or forgery any funds, assets or properties provided or insured under this title shall be fined not more than $10,000 or imprisoned for not more than 5 years or both.

If it is less than $200 the felony is a little bit less, I think.

Senator ABDNOR. That is if the parent does it. Are there some cases where students—conceivably the parents aren't even aware of that.

Mr. ZAGLANICZYNY. I'm sorry?

Senator ABDNOR. Isn't it possible for the student to apply——

Mr. ZAGLANICZYNY. The student generally on all loan applications has to file a statement and sign a statement indicating that those funds would be used purely for educational purposes.

Senator ABDNOR. We do know it goes on. How do you suggest tightening it up? We better come up with some kind of a proposal. Do you have anything to suggest to make it a little tighter?

Mr. ZAGLANICZYNY. I don't have anything to suggest at the moment. The reason I am here testifying is that all my colleagues, my bosses, so to speak, are meeting as we speak to discuss ways to reduce the costs in the student aid programs and we will be coming up to the Hill and working with the administration in the near future. But at this point we are still in the talking stage. We are looking at all types of options. We recognize that it is going to be a very tight year. We recognize that we have to take our fair share.

We do disagree, however, in the way the administration has proposed some things, and we will have some alternatives so that we can keep the programs viable, moving, and the students especially.

Senator ABDNOR. Now we are talking about cuts. I am talking about where abuses arise. I think that is extremely important.

You have a breakdown by state. I am very proud of South Dakota's attainment in your facts. I think it is 1.8 percent in default. We have a rather unusual setup. I understand that other States have come out to look at it. Unfortunately the rate of default is much higher in many other States?

Mr. ZAGLANICZYNY. In the GSL program? The GSL program default rate, as I recall, it is just around 9 percent, which is a little bit less than most consumer type loans that have been given out. The administration, the last administration really—we applaud them on this—cracked down. It is embarrassing to come up to the Hill and testify about a program that had a high default rate. But the last administration went ahead and really cracked down, and we were pleased to see that because it makes the program that much more politically viable on the Hill. We don't want to be embarrassed by a high default rate. So that has been cracked down on. The Educational Amendments of 1980 added a few more penalties. Now if a student defaults on a loan their name will be reported to a credit bureau. So that will be another incentive for people to pay back loans so they don't have a bad credit rating. That is just a change in the law, and I think that will be a good one to make sure people pay back the loans.

Senator BURDICK. I guess that is all of the questions we have. We thank you for your appearance here today.

[The statements follow:]

STATEMENT OF FATHER WILLIAM L. GEORGE, S.J.

Mr. Chairman and Members of this Committee, I am Father William L. George, S.J., Special Assistant to the President of Georgetown University. With me is Mr. Francis F. Mills, Director of Financial Planning at Boston College.

We wish to address the Higher Education Academic Facilities program, particularly, Graduate Facilities and College Housing and Annual Interest Grants.

The Recissions for FY'81, revised for the Department of Education and submitted by the President (on page 111), proposes to close the College Housing Loan Fund and removes "the need for an annual appropriation for the the payment of participation sales insufficiencies."

This proposal takes the income from the repayments to the loan fund made annually by college and universities as well as the authority for the entire fund out of the annual jurisdiction of the Congress. The use of these funds then becomes subject to the discretion of the Secretary of the Treasury without congressional approval. This circumvents the jurisdiction of the authorizing and appropriation committees for this program. We recommend that the Secretary of Education report the activities within this fund annually as has been the practice since 1954.

The Revised '82 Budget eliminates the College Housing Program by requesting blanket authority and substitutes Treasury control for that of Congress. I would ask the Committee to retain the College Housing Loan Program within its jursidiction.

Though the Budget gives a decrease in enrollments as the reason why there is not a federal role in this program, the fact is that college freshmen applications are up 13% in 1981 (Chronicle of Higher Education, March 2, 1981), and, overall enrollments are expected to rise.

Approximately $454 million in applications were submitted under the College Housing Loan Program in 1980, with $83.6 million being funded. There remains a critical need for housing in many urban colleges and universities throughout the Nation. With rising transportation costs, and high commercial rents, students need and want to live on campus. We urge the Committee to keep active this very effective program.

ACADEMIC FACILITIES

The Nation has over $75 billion invested in Higher Education Academic Facilities. Over $1 billion in construction, re-construction and renovation is expended each year. There is critical need for major renovations and replacement. The replacement of these buildings in 1978 dollars was estimated at $105 billion (Financial Statistics of Institutions of Higher Education, FY'78, Pg. 150).

Under Title VII-B of the Higher Education Act of 1980, PL 96-374, the Committee authorized $80 million in order to stimulate universities to refurbish their facilities. Appropriation of $80 million in grant funds will stimulate a minimum of $80 million in matching institutional funds towards a total program of $1 billion. We also recommend the appropriation of $10 million in Annual Interest Grant funds for graduate facilities.

Depending upon commercial interest rates, annual interest grant outlays can result in private sector financed construction equivalent to 10 to 25 times the annual outlay.

The first criteria for the use of these funds as contained in PL 96-374 is for Academic Facilities, that are designed for energy efficiency using coal, solar and other renewable energy sources. The benefit from such a construction program would be jobs, rejuvenation of cities (where 90% of the Graduate Schools are located), energy conservation, and the academic benefit to 10 generations of students per facility. Thus, a modest federal fund stimulus would start a large and needed construction program where Graduate Schools, that portion of Higher Education Facility in most need of replacement and renovation, would be replaced by facilities that produce energy saving (coal) and produce energy (solar).

We would ask the Committee to appropriate $80 million for Graduate Facilities grants and $10 million in Annual Interest Grant Funds, which could generate over $1 billion in nation-wide construction projects.

BOSTON COLLEGE

Title VII of Public Law 96-374, the Higher Education Amendments of 1980, contains several forms of assistance to colleges and universities for construction, reconstruction, and renovation of academic facilities. These are in the form of grants, loans, and interest subsidy grants.

I wish to express the interest of Boston College in the Annual Interest Grant Programs particularly for graduate facilities. The Interest Grant Program, which first required appropriation in FY'69, developed assistance for academic facilities to the extent of approximately $1.4 billion dollars, the interest grant for which is currently budgeted at $25.5 million dollars for FY'82. The amount of these annual subsidies on previously approved projects will decrease gradually each year as loans subject to such subsidies are retired.

We belive that the Interest Subsidy Program should be expanded. The program operates when a college has arranged a loan from the private sector. The interest subsidy provides for reducing the net cost of interest to the borrowing institution to 4% per annum.

A relatively modest annual interest subsidy cost to the Government can result in substantial and immediate construction and reconstruction for colleges and universities with such needs.

We further would recommend that for cases of special and critical need, the Committee consider providing annual interest grant subsidies to those institutions with such needs who have already commenced construction but who have not yet arranged for permanent long term financing.

We also recommend that in cases of special and critical need the Secretary of Education be granted authority to waive campus loan limits, and maximum state limits.

The attached table at varying interest rates, and for terms of 20, 25, and 30 years, respectively, indicates the relative debt service cost for a commercial loan of $10 million dollars. This table illustrates the dimension of construction costs which can be supported by modest Annual Interest Grants.

TABLE I

COMPARATIVE ANNUAL DEBT SERVICE COSTS
ON COMMERCIAL LOAN OF $10,000,000
(at various interest rates and terms)

at int.rate of	for 20 years	for 25 years	for 30 years
9.0	$1,086,863	$1,012,043	$ 969,085
10.0	1,165,563	1,095,535	1,056,564
11.0	1,246,407	1,181,229	1,146,141
12.0	1,329,231	1,268,886	1,237,514
13.0	1,413,875	1,358,279	1,330,409
14.0	1,500,183	1,449,197	1,424,585
15.0	1,588,066	1,541,448	1,519,828
16.0	1,677,203	1,634,857	1,615,959

COMPARATIVE ANNUAL DEBT SERVICE COSTS FOR VARIOUS TERMS

4.0	$ 731,115	$ 636,464	$ 575,359

COMPARATIVE ANNUAL INTEREST GRANTS
(based on the above)

9.0	$ 355,748	$ 375,579	$ 393,726
10.0	434,448	459,071	481,205
11.0	515,292	544,765	570,782
12.0	598,116	632,422	662,155
13.0	682,760	721,815	755,050
14.0	769,068	812,733	849,226
15.0	856,951	904,984	944,469
16.0	946,088	998,393	1,040,600

NOTE: All data above are based on semi-annual debt service payments at end of each period.

STATEMENT OF RICHARD J. SMITH

On behalf of 55 state and territory program administrators, I want to express my appreciation for having an opportunity to present testimony relevant to the appropriations legislation currently under consideration.

I call to your attention the fact that the October, 1980 enactment of Title I-B Education Outreach Programs represents the only major postsecondary continuing education program directly authorized by Congress. The Congress must be commended for its extensive and purposeful work over an 18 month "Reauthorization process" in developing a humane response to providing equal access and equal opportunity for the learning needs of adults; particularly those underserved and unserved.

The Congress should know that in its wisdom and hard work, the new Law is most consistent with the outpour of adult learner needs expressed by representatives of community-based educational institutions, business, industry, labor, a wide range of institutions and most important, the very people whose age, sex, race, handicap, national origin, rural isolation or economic circumstances pose barriers to their learning needs.

The median national age is now approaching thirty years. The Nation's declining birth rate since 1960, and its resulting decreased enrollment of school-age children, has forced the closing of more and more primary and secondary schools. The impact of this demographic change is beginning to be felt by postsecondary institutions. In many colleges and universities, traditional enrollments by eighteen to twenty-four year olds have either leveled or have started to decline. In these same institutions, however, enrollments by older adults, who usually study on a part-time basis, have reached record numbers.

Postsecondary continuing education for adults is the most rapidly expanding part of American higher education. As welcome as this growth is, there are danger signs which ought to concern the Federal Government. Current participants in postsecondary continuing education, for instance, are disproportionately White. Blacks and Hispanics are not proportionately represented. Moreover, compared to the average adult population, these participants are relatively more affluent, better educated, and more likely to be employed. In short, continuing education is often reserved in our society for those who have already done comparatively well in society.

Title I is the only Federal program solely and exclusively designed to conteract these inequities. Title I serves those who have been by-passed by the mainstream of American higher education. It puts into practice the Congressionally espoused principles of equity of access and equal opportunity in higher education. It especially serves the older American and the economically and socially disadvantaged. It reaches out to serve those in geographically isolated areas, as well as those in urban areas who have been psychologically isolated from higher education, but who nonetheless may live within the shadows of higher education institutions.

Title I is a State grant program. It helps the Federal Government work closely with all states in a State and locally determined identification of adult learning needs. It is a matching program which has consistently generated more local funds than is required of the program. In this sense, it is far more cost effective than originally anticipated.

Title I is an incentive program. It encourages non-Federal public dollars and private sector support for continuing education. It is also a demonstration program whose successful activities have been replicated nationally and whose experimental approaches to adult learning have been adopted and used by countless institutions.

With the dramatic demographic changes taking place in the American population, and reflected in the patterns of higher education enrollments, it is important that Congress rethink its long term commitment to adult learners. The Council believes that the Education

Outreach Program moves in the right direction and deserves your support.

These new directions were to have been implemented this year. For them to succeed, the rescission request must be denied and a $15 million appropriation be released for this critical transition year. Without your support, the Federal/State/institutional partnership for continuing education that Title I has helped to construct over the past fifteen years will be undermined and, in many instances, may collapse.

An estimated 700 projects are ready to begin operations. They were designed by people representing combinations of both the public and private sectors and recipients themselves. Examples include (1) diagnostic testing, assessment, counseling and education for unemployed and underemployed adults, (2) converting unemployment time produced by recession into periods where workers can learn skills helpful in finding employment, (3) information and counseling about career options, requirements and opportunities, (4) nutrition site education for the elderly, (5) job training for the handicapped, (6) community mobilization for economic development, (7) matching adult education with adult workers educational interests, (8) utilizing public television for rural based adults, (9) issues of employment and the elderly, and (10) information on the cost of education and Federal, State and institution financial aid available.

In January, 1981, State governors received information relative to the Education Amendments of 1980 and a request to develop Federal-State agreements. This Federal-State agreement process has already linked and consolidated planning bodies with Education Information Center groups and continuing education program personnel. Equally important, the agreements already reflect State and local determination as to critical program and population needs.

In sum, the Title I-B legislation has mobilized the development of State Block Grant processes and initiatives...the only higher education program that is consistent with President Reagan's intent of placing determination responsibilities with the states.

As State and Territory program administrators, we ask this Subcommittee to deny the fiscal year 1981 rescission request that is currently before you and take positive action in the release of such funds. The States are in an immediate position to leverage the Congressional Continuing Education Outreach Program.

The Administration's fiscal year 1982 Title I-B budget request for zero funds would not only be extremely disruptive throughout the postsecondary communities, but even appears to be directly inconsistent with Congressional intent and actions. We do not concur with the Administrative action, but request a $25 million fiscal year 1982 appropriation. This would permit all States and Territories to carry out the intent of Congress. A $25 million appropriation would mean a Federal investment equivalent to $1.30 for each of the nineteen million adults now participating in adult and continuing education.

STATEMENT OF CHARLES E. TAYLOR

Mr. Chairman, members of the Subcommittee, my name is Dr. Charles Taylor, President of Wilberforce University, a United Negro College Fund institution founded in 1856. I am pleased to have the opportunity to appear before you today to discuss the continued funding of programs vital to the enhancement of America's education.

The United Negro College Fund represents a consortium of 41 predominantly black colleges and universities. All are private and fully accredited. These UNCF institutions provide a quality education for 50,000 young men and women. These UNCF institutions are in the finest tradition of plurality in this nation and have produced the most significant cadre of leadership which has contributed to the most beneficial changes in this nation for more than a hundred years.

Today, I would like the Congress to know that the UNCF is supportive of efforts to solve the economic ills of our country; remedies are needed by the most talented minds available. Talented minds trained at postsecondary institutions in our great country. To ensure the future prosperity of this nation, we must endeavor to make sure that "no mind is wasted." To ensure a bright future for America, we support funding of education programs that will achieve that end. We support our distinguished colleagues in the higher education community in appealing to the Congress to keep higher education for our young people high on their agenda. This support must be constant and not be allowed to fluctuate with other programs of marginal returns. Therefore, we appeal to you to act swiftly in reaching your decisions regarding supplementals for the remainder of FY'81.

Like many of our colleagues in higher education, the United Negro College Fund has gone on record in support of the Middle Income Assistance Act (MISSA). We believe that federal help should be available for those students who come from families that are on the lower end of the middle-income scale.

We believe it to be an appropriate role in the federal government to protect first the interest of those who because of their economic status have no voice amplifying their desperate concerns.

This brings me to my first concern, the Administration's constant reference to serving the neediest students. I, as of yet, have not been able to get a handle on what their criteria of "neediest" means. I, and my colleagues, would hope that neediest actually reflect that group of students from families whose income for a family of four reflects the Bureau of Labor Statistics' standards which has established $12,900 as a minimum income of adequacy. Families that live below that level of income have no surplus funds that are not encumbered. All of their income is obligated; otherwise, they would not be in the low income category. In my view, the term needy extends above the $12,900 income level. The escalating costs for a postsecondary education is now beyond the reach of most families on the lower middle income level. MISSA has increased Pell Grant Award recipients in this lower middle income category by some 46% up from 3.8%.

The United Negro College Fund is also grateful that the administration has strongly signaled its support for Title III. "Strengthening Developing Institutions" and particularly for Part C of the Title III program, "Challenge Grants." The Challenge Grant program was jointly conceptualized by the old Office of Education and the United Negro College Fund to encourage and provide federal resources and private funding for institutions desirous of reducing their dependence on federal resources for general operating expenses.

I would hope that the Congress would remember that every thing you cut is cut at a price. Even budget cuts are not free. The cut in training and education programs is going to engage a cost in loss of trained resources for the very industrial development that is being proclaimed for the private sector. Moreover, it produces more persons on the dependency side where seemingly plans are being made for decreasing dependency, unemployment and training opportunities for employment. Increasing the potential of persons that will be on the earning and tax contribution side of the national ledger would be lost to the impact of these cuts.

"There is no way that the Public Sector can escape the cost of producing dependency." For those intelligent citizens who will refuse dependency, the cost of incarceration is 4% to 10% higher than to educate that person and that includes tuition, room and board.

SUPPLEMENTAL FOR FY'81

Pell Grant

UNCF recommends a supplemental appropriation for Pell Grants of $1.3 billion to enable a maximum Pell Grant to crest at $1800 for FY'81. This projection has been recommended by the Congressional Budget Office. This is still short of the maximum authorized in the Higher Education Act of 1980 for FY'81 for $2,160.

To hurriedly debate and, in an untimely manner, implement untested and quickly analyzed program changes in a program that has taken years to structure could harm needy students most and those institutions whose mission it is to serve them. Time is needed for a thorough analysis of the impact the new proposals will have on the already troubled economic fabric of this country's institutions of higher education.

Rationale

1. Failure to increase the supplemental to $1.3 billion would:

   - Disorient projections anticipated by many low-income students who have no means of accommodating the short fall. The administration has currently, and the Congress has historically supported the premise that Pell Grants be targeted to the needy. UNCF concurs in this intent and believes this sensitivity to support a supplemental funding of $1.3 billion would reflect the sincerity of Congressional intent.

   - Student Eligibility Reports - (SER's) cannot be distributed to institutions until supplementals are approved, thus, hindering student aid offices from processing student aid packages satisfying remaining need for needy students entering this fall. This delay will wreak havoc at all post-secondary institutions across the country, especially ours who serve the needy with understaffed Student Aid Offices. It has been documented that in 1978 when there was a serious delay in processing Pell Grant Awards, black colleges experienced a 20% enrollment drop. Again, we are being threatened with this dire consequence; since 71.5% of the students at UNCF institutions are on Pell Grants, and a large percentage of those qualify and receive the maximum award.

   - A reduction in Pell Grant Awards for students of need from an anticipated maximum of $1,800 to $1,100 or even $1,750 would make impossible the enrollment of most of our current students altogether. These students are already financially insecure and unable to make up from private sources the difference that would be required to keep them in school. For the past fifteen years, from 80 to 90% of the student population of each of our institutions have been in the category of the needy as measured by the criteria of BEOG and the other Federal student aid programs.

- UNCF recently conducted a study at its member institutions and has issued a report that indicates that Pell Grants equal only one-fourth of all the aggregate financial needs of our students. The study revealed important evidence which indicates that UNCF students are probably not receiving the total amount of Pell Grant Aid to which they may be entitled. In fact, the data suggest that almost $67 million in Pell Grant Aid should be available to UNCF College students in 1980-81. That represents over 42% of the students' aggregate financial need and 77% more than the students received in 1978-79. If Pell Grant Aid to our students are reduced, the effects on our students and institutions will be seriously undermined.

- The National Institute of Independent Colleges and Universities released statistics which indicate the relevance of MISSA to our private institutions. The percent of dependent students on Pell Grants with parental adjusted gross incomes below $6,000 increased from 80.3% to 91.7%; from $6,000 to $12,000, the percent of recipients increased from 79.1 to 88.9 %; from $12,000 to $18,000, from 47.8 to 78.4%; from $18,000 to $24,000, from 15.1 to 68%; and from $24,000 to $30,000, from 3.8 to 46%. UNCF will continue to support MISSA as long as it does not divert resources from those students on the lower end of the scale.

A. Self Help requirement of $750 in FY'81 could be disastrous to UNCF students.

It is unclear how the administration plans to implement the $750 Self Help Requirement. I would hope that the Congress recognizes the uncertainties in this policy for the uncertainties far outweigh any positive result of implementation.

Rationale

- This proposal can further delay the Congress in making decisions that must be made quickly to protect the students and the institutions who cannot plan adequately for the fall semester until (SER's) have been distributed.

- Any student at a UNCF institution that would be required to make a self help contribution of $750 over what is already expected of them in most cases would not be able to continue their education. Over 90.2% of our students are on financial aid, and 71.5% of them are on Pell Grants and are currently barely able to meet their financial obligation to stay in school.

- The unemployment rate for black youth has never been below 20% in the last 30 years. It now publically stands at 36.77%, but that percent drastically falls short of the estimates made by responsible public organizations which place black teenage unemployment at 60% or more. The reason the percentages have not gone even higher is the fact of educational opportunities through Federal Student Aid. To implement an additional $750 burden on our students, would be devastating to them, to our institutions, and to the nation now and in the future.

  - The average annual family income of all dependent students enrolled at UNCF institutions in 1979-80 was approximately $8,000.

- The $750 self help recommendation is apparently in addition to the tax on student earnings which are already calculated in the Family Contribution Schedule. The Family Contribution Schedule used in calculating grant awards would be revised to eliminate any adjustment to account for the increase in the Consumer Price Index — an adjustment that has been made every year since the inception of this program.

- Changes of this type would do serious harm to the needy. In academic year 1980-81, the family of four offset was $7,700; in 1981-82, $8,650. This proposal implies that a family of that low an income level is capable of contributing to their children's education. Mr. Chairman, if reductions are absolutely essential, I submit that the more equitable rateable reduction provided for in the law be followed.

B. Elimination of the Administrative Allowance

Experience has shown that institutions with a large percentage of students receiving financial aid have a disproportionate burden that the $10 allowance was designed to offset. The provision to eliminate the $10 allowance would have a disproportionately serious impact on the historically black private colleges.

- The elimination of the administrative allowance which is already a bare figure would add a tremendous burden on our schools' ability to monitor and maintain accurate records. Our institutions are currently understaffed and underfinanced to provide the government the information it seeks, and take care of the prolific student problems which student aid engenders.
- The cost to the Federal government if they were to administer the campus-based program would be staggering. The argument to cut is artificial because if the colleges are not allowed to have indirect cost benefits they will have an unbearable burden.
- The institutions are actually rendering a service to the Government. The criteria, rules, and regulations, are all defined by the Government. The only thing the institution does is to provide the trained personnel to administer the programs. Either the programs will not be administered on the local level, or the total cost of the implementation will be paid by the Federal government.
- There are no resources at our private institutions to pay the cost of the administration of the student aid program, and we have over 80% of our students on student aid.

The United Negro College Fund supports the Congressional Authorization of $10 per BEOG recipient.

C. Assessment rate change for 14% to 20% (Family Contribution Schedule)

A change in the current assessment rate could potentially deal a serious blow to the needy.

Rationale

- Current law requires that the expected family contribution for a student be determined by multiplying a family's discretionary income by an assessment rate of 14% when that family has an adjusted gross income of $25,000 or less. This administration is asking to raise that assessment against poorer families.
- The Higher Education Act calls for a single needs analysis and a single form for student assistance programs. Any change to the assessment rate should be done through the normal process. In that way, the rate can be constructed so as to protect the neediest students while dealing with budget considerations.

D. Family Contribution Schedule to be increased while not including an inflation allowance:

- The administration proposes to revise the Family Contribution Schedule used in calculating grant awards by eliminating any adjustment to account for the increase in the Consumer Price Index — an adjustment that has been made every year since the inception of this program.

- Low- as well as middle-income families will be hurt if the Congress accepts this recommendation.

- To redesign the Family Contribution schedule now will make the disbribution of the Student Eligibility Requirement (SER's) seriously late, compounding problems for students and their institutions.

- Many poor and low-income students would be discouraged from attending college especially when this adjustment is tied in with the new $750 self-help contribution.

National Direct Student Loan (NDSL)

UNCF supports a supplemental of $100 million to fund NDSL at the level it was funded in FY'80.

Rationale

1. Failure to fund a supplemental appropriation at the $100 million level could have the following adverse effects on UNCF institutions:

- A decrease in NDSL loans for needy students would be extremely debilitating to them because most of our students are extremely poor and cannot secure Guaranteed Student Loans from commercial banks. 23.3% of students at UNCF institutions rely on NDSL as compared to 4.7% on GSL.

- Financial Aid Offices at our private institutions would be unable to develop student aid packages for students of greatest need. This could discourage student enrollment and cause all kinds of fiscal problems for the institutions, which are already plagued by ever increasing economic hardships.

APPROPRIATIONS FOR FY'82

Title III (Strengthening Developing Institutions)

The United Negro College Fund respectfully urges full funding of Title III as recommended by the Authorizing Committee at a FY'82 level of $160 million and that includes the new Challenge Grant program at $25 million. We are grateful that the Administration supports Title III and the new Challenge Grant program. UNCF feels the Challenge Grant program offers a special challenge to postsecondary institutions to match federal funds with private and state funds. This program will be of monumental assistance not only to small, private institutions which do not have the enormous financial base as the larger private institutions such as Harvard, Princeton, or Stanford, but also to the public institutions. Under this program, the small institutions will be able to increase their independence from the need for federal funds for general operating expense purposes.

Rationale

1. Failure to fund Title III at its authorized FY'82 levels could potentially have the following negative effects on UNCF institutions and undercut the positive progress being made at UNCF institutions in the following areas:

- Enrollment: In the past ten years, the average enrollment per UNCF institution has increased 11.9%, attritutable to Title III, while the average enrollment at private four-year colleges nationally increased only 2.3% during the same period. The average enrollment per UNCF institution rose from 972 in 1969 to 1,088 in 1978; private four-year colleges nationally increased from an average of 1,630 per institution in 1969 to 1,667 in 1978.

- Endowment: The average endowment per student at UNCF institutions rose 22.4% between 1971-72 and 1967-77. At private four-year institutions nationally, the average endowment per student increased less than 1%.

- Curriculum Development: Private black institutions have managed to restructure their curricula in the past decade to meet the newer distribution of job opportunities for blacks in the labor market. In 1978, almost one-fourth (23.3%) of degrees earned were in business administration, more than three times the 6.8% of graduates at our institutions receiving business degrees in 1968. Fifteen UNCF institutions offered and awarded degrees in the health professions in 1977-78, compared to only two in 1969; the number of communications majors jumped from 22 as of 1974-75 to 171 in 1977-78; and 26 UNCF institutions have established dual degree engineering programs in cooperation with engineering programs in cooperation with engineering schools. Prior to 1967, no such programs existed.
- Title III has helped to improve our management capability by providing funds for participatory planning, management, and evaluation systems.
- It has enabled the colleges to operate such programs as Faculty Development, Counseling Services, Career Planning and Placement, Bio-Medical Programs, Student Recruitment Services, Student Personnel Services, Specialized Instructions, Long-Range Planning, Cooperative College Development, Test-Taking and Learning Skills, Learning Resource Centers, Freshman Studies Programs, and Institutional Research.
- In the Student Services area, improvements have been made in counseling, testing, and financial aid. Funds have provided for cultural enrichment activities and Living-Learning Centers have been used to provide additional exposures for students.
- Faculties: The faculties at UNCF institutions have always been interracial and underpaid. Yet, these institutions have been able to attract instructors with advanced degrees. Of all full-time members, about 60% are black, 30% white, and 10% other. Faculty salaries, of full-time professors, are about 25% lower than the national average at colleges and universities. Of all full-time faculty members, approximately 40% hold Doctoral degrees.
- In testimony to the effectiveness of UNCF faculties, they start with a high proportion of students coming from disadvantaged backgrounds and/or inferior high school systems. However, these UNCF instructors prepare their students so well that many are accepted at top-rated graduate schools all around the country.

Title IV (Student Aid)

The United Negro College Fund feels the need for continued funding in student financial assistance programs for the neediest students remains clear.

Pell Grants

The Basic Educational Opportunity Grant program has enabled many students, principally the young, black and minority student to pursue higher education. Therefore, the UNCF supports funding of the FY'82 authorized level of such sums that will enable a maximum award of $1,900.

National Direct Student Loan (NDSL)

The United Negro College Fund supports funding for FY'82 at the level authorized by the authorizing committee at a level of $400 million.

Title VII (Construction, Reconstruction, and Renovation of Academic Facilities)

This new Title contains provisions which state allowable purposes for construction and renovation projects. It permits instructions which historically enroll the traditional poor who are away from the mainstream of access to private financial support to obtain funding for construction and renovation of educational facilities. UNCF supports this Title at full funding at $580 million because as long as there are minorities, our institutions will continue to grow.

STATEMENT OF SANDRA TIMMERMANN

Mr. Chairman, I am Sandra Timmermann, the Head of the Institute of Lifetime Learning of the National Retired Teachers Association and the American Association of Retired Persons (NRTA-AARP). I am here today to urge you not to accept the proposed rescission of FY 81 funds for Title I of the Higher Education Act - Education Outreach - and to appropriate $20 million in funds for FY 82 for this modest but important program. In the long run, the appropriation of funds for Title I will add to, rather than detract from, the effort to bring the federal budget into balance.

Mr. Chairman, the cornerstone of federal policy in postsecondary education has long been the advancement of equal educational opportunities. Thus it was most appropriate that the Congress in 1980 sharply focused Title I so that its primary objective is to improve access to postsecondary education for adults, particularly those who have been unserved, such as older persons, low-income individuals, the unemployed and underemployed, women who must return to the labor market, the rurally isolated and others who face significant barriers to postsecondary opportunities. In doing so, the Congress eliminated some less necessary activities and placed greater emphasis on services which will help promote access to educational opportunities.

At the same time, Title I underwent another significant improvement, through the consolidation of three previously separate but related programs: old Title I-A (Community Service and Continuing Education); Title IV, Subpart 5 (Educational Information Centers) and Statewide Planning (previously part of Title XII). As a result of this consolidation, administration of the programs has been streamlined and states have been given greater flexibility and are subject to less paperwork and structural requirements. For example previously states were required to submit 3 separate annual plans; now they enter into a single federal-state "agreement."

A loss of funds, whether by rescission of already appropriated funds in FY 81 or by a failure to appropriate FY 82 funds, would mean a direct loss of informational, education, and support services which enable adults to gain the postsecondary education necessary for employment, to cope with family responsibilities and to achieve or remain self sufficient. For example, Title I has supported the following kinds of activities:

-- a ten-week program of courses in career planning, science, mathematics, and study skills for women who have been out of formal education but who now need education in order to return to the labor market for economic reasons.

-- a twelve-week training program (offered twice a year) for training home care providers as an alternative to institutional care; participants are unemployed, disadvantaged minorities from inner city areas who are trained to be certified home care workers.

-- a course on preretirement education for older workers to improve the quality of working life prior to retirement and to help them plan for economic stability after retirement;

-- a program providing six-week courses designed to reduce obstacles to returning to education on the part of adults, such as blue collar workers; this program does so by providing education in effective reading, writing, study skills and career advisement, to assure that program participants can begin and successfully pursue postsecondary education.

-- toll-free education and career information "hotlines" operated by a number of states to provide state residents with up to date, comprehensive information on career possibilities, educational programs, and financial assistance with which to make more informed decisions.

A loss of funds would disrupt the federal-state partnership in this area, whereas, a modest amount of federal dollars can leverage additional state resources. At a minimum, states are required to provide matching funds. In fact a number of states provide more than the required amount.

However, the case for Title I is more than the past or current services provided under the three programs now merged under it. It grows also from the large disparities in participation of adults in education. While participation in education by adults spans a considerable range of backgrounds, educational experiences, and incomes, it is greatest among one broad group: those who are young, white, well-educated, and earning salaries above the national median family income.

For example:

-- 15.8 percent of those between 17 and 34 years of age take advantage of adult educational opportunities (excluding those enrolled full-time in secondary or postsecondary institutions), whereas only 4.4 percent of those over the age of 54 participate. Moreover, there are over 2.5 million persons 65 and over who are functionally illiterate.

-- 12.5 percent of white adults participate in adult education, whereas only 6.5 percent of blacks participate.

-- 26.8 percent of those with four years of college or more participate, while 11.2 percent of those with only four years of high school do (and only 3.4 percent of those with less than high school diplomas).

-- 17.7 percent of those with annual family incomes of $25,00 or more participate while only 8.4 percent of those whose income is between $5,000 and $10,000 and only 5.4 percent of those with incomes below $5,000 participate.

Equally important, present research indicates that the majority of adults enrolled in education have returned to formal learning because of specific job or career related factors--to obtain or keep employment or avoid job or skill obsolesence - or because of dislocations in their personal lives such as divorce or death of a spouse. For example, we know that older adults seek education for second careers and to acquire job skills. In a recent national survey of adults age 55 and over conducted by NRTA-AARP, 49% of the respondents indicated that this was one of the most important reasons for participating in education.

Other research points to obstacles faced by prospective adult learners. Many adults who are not now participating in education are those who did not attend school or perform well in school when they were children. They are reluctant to return to the scene of former failures. Others face logistical barriers--workers and homemakers find the times, places, and instructional formats of much traditional postsecondary education incompatible with the demands of their daily lives. Because they have been out of the educational system for years, many adults lack even the most basic information on where to find educational opportunities suited to their needs and the financial assistance to pay for it. Therefore, Title I provides that educational programs and services be offered in a wide range of settings, appropriate to the needs of adults.

It is to these and similar obstacles that Title I is addressed. The recent reauthorization of Title I was cognizant of the limits on funding. Thus it placed a heavy emphasis on utilizing resources already available but currently inaccessible to adults. The funds provided by Title I, while modest, are a signficant leverage - a door-opener if you will - for adults to the existing postsecondary educational system.

In summary, Mr. Chairman, Title I should continue to be funded for the following reasons:

1) Title I is focused on promoting education opportunity for those most in need;
2) its recent consolidation streamlines and makes more flexible the provision of services by states and local providers, with less paperwork and structural requirements;
3) a modest provision of funds will enhance the federal-state partnership and facilitate better use of existing resources;
4) lack of opportunities to participate in education leaves older persons, the handicapped, those of low-income and other underserved adults unable to improve their lot in the labor market and society;
5) obstacles to adult learning are addressed through the information, support services and educational activities supported through Title I; and
6) it is likely that, at least in the long run, the expenditure of funds for Title I, will return to the Treasury more in terms of tax payments than was appropriated for it in the first place.

Thank you Mr. Chairman for the opportunity to bring Title I of the Higher Education Act to your attention. I would be pleased to respond to any questions.

STATEMENT OF LAWRENCE S. ZAGLANICZNY

We appreciate this opportunity to present recommendations for FY 81 Supplementals and FY 82 appropriations for higher education programs of the Education Department, on behalf of the national organizations representing all types of institutions: independent colleges, community colleges, state colleges, historically black colleges, land-grand institutions, and research universities.

Our highest priority is to maintain the national commitment to make postsecondary opportunities available to citizens without regard to income, race, sex, or geographic location. In this time of budgetary stringency, it is essential that necessary reductions in higher education programs be made in ways which do not restrict postsecondary opportunities, and deny a college education to any qualified student.

Therefore our statement deals entirely with the major student assistance programs authorized by Title IV of the Higher Education Act, and does not address the many important categorical programs which provide institutional support for a variety of national purposes. Our greatest concern is to maintain funding of the student assistance programs at approximate current levels.

We must emphasize at the outset that, in addition to cuts in student aid and the categorical programs of the Education Department, the Administration is proposing reductions in dozens of other programs in other federal agencies which would have a serious impact on higher education. These proposals are of sufficient magnitude to cause a decline in quality at all types of institutions, as universities lose funds for research in the social sciences and training in the health sciences, four-year colleges lose support for science education and the humanities, and community colleges lose funding for occupational training.

We are most concerned with the cumulative impact of the proposed cuts in terms of restricting access and choice for hundreds of thousands of students throughout the country. The impact will be felt by low-income families, for whom Basic Grant assistance is proposed at the FY 79 level although costs have gone up 30 percent since then, and by middle-income families, whose students will be denied the aid extended by Congress through the Middle Income Student Assistance Act of 1978.

FY 81 Supplemental

We have already called the Subcommittee's attention to the urgent need for an FY 81 Supplemental of $911 million for Pell Grants and $100 million for Direct Loans to avert a critical shortage of student assistance funds this spring. Our letter of February 9 (attached) details the specifics.

The Administration is proposing a $661 million supplemental to pay a $1,750 Pell Grant maximum. We urge prompt passage of the supplemental, and immediate resumption of processing of Pell Grants based on the existing family contribution schedule and cost of attendance regulations.

We also urge a $100 million supplemental to restore the National Direct Student Loan program to the FY 80 level of $286 million in federal capital contributions, rather than the $186 million level of the Continuing Resolution. Unless this amount is restored, some 135,000 needy students would be forced out of the program. States will also bear an inequitable share of the cuts, with some receiving substantial reductions in their NDSL allocations and others none. While the Administration has not requested a supplemental for NDSL, it has requested the full $286 million for FY 82. We ask that this level be sustained for FY 81 to avoid serious reductions and dislocation of funds for one year.

We must emphasize the vital importance of assuring final congressional action on these issues before the end of April. To defer action on this matter until summer will result in massive disruption of the processing system for student aid. If institutions cannot make award commitments to students before the spring term ends, some 5,000,000 students will be unable to make plans to continue their education in the fall. These students, their parents, and colleges throughout the country are anxiously awaiting your decision on these matters.

FY 82 Appropriations: Student Assistance

Pell Grants. We recommend a $1,900 maximum for Pell Grants to retain students currently eligible for the program, and to address the needs of the poorest students who do not have the family resources to meet the costs of college which have risen 30 percent since the maximum was set at $1,800 in Academic Year 79-80. The $1,800 maximum proposed by the Administration for Academic Year 82-83 will be worth only $1,350 in Academic Year 79-80 dollars. Failure to increase the maximum will not only penalize the neediest students (doubly jeopardized by the proposed phaseout of Social Security educational benefits), it will not restore the eligibility of the 200,000 students from middle-income families who would be dropped from the program by failure to increase the maximum in FY 81.

We have serious concerns with the Administration's proposals to restrict eligibility for the program, which would eliminate some 600,000 students with family income in the $19,000 - $25,000 range. This step would, in effect, repeal the Middle Income Student Assistance Act of 1978, which was enacted in specific recognition of the need to help these families meet the rising costs of college education. The need which existed three years ago is even more acute today, and cutting these families off from this basic source of support would constitute a serious restriction of post-secondary opportunities. The Administration's proposal for a $750 "self-help" requirement also raises some concerns because it appears that it would only impose reductions on students attending low-tuition public institutions with family incomes between $8,000 and $15,000.

We estimate that a $1,900 Pell Grant could be provided for slightly above the Administration's cost estimate for an $1,800 maximum through some adjustment of the family contribution schedule which will be submitted to Congress in the spring.

We would appreciate the opportunity to work with the Subcommittee to develop specific changes which would spread the burden more equitably throughout the eligible population.

Supplemental Educational Opportunity Grants (SEOG). We recommend $395 million in funding for this program, which supplements Pell Grants for low- and middle-income students attending higher-priced public and independent institutions. Wide variation in the availability of state grants, and expected pressures on other assistance to students in higher-priced institutions, make it essential to recognize the need for at least a minimum cost of living adjustment for this program rather than the $370 million recommended by the Administration -- the level since FY 80.

State Student Incentive Grants (SSIG). We recommend a small increase to $100 million from the $77 million recommended by the Administration for this program which provided 50-50 matching funds for state student grant programs. At a time when state budgets for education are being cut back throughout the country, this incentive for the states to continue their own support of student assistance is particularly important.

College Work-Study (CWS). We recommend $600 million, a $50 million increase for this unique program which provides self-help for low- and middle-income students. Although the Administration proposes level funding, some increase is essential in view of demands on the program which are expected to increase significantly due to cutbacks in Social Security educational benefits, restriction of loan availability, the decline of graduate fellowship opportunities, and the expansion of the program authorized by the 1980 Amendments.

National Direct Student Loans (NDSL). We recommend $300 million for federal capital contributions to the Direct Loan program, a $14 million increase over the Administration's proposal. All recipients of Direct Loans have documented need, and with expected cutbacks in the availability of Guaranteed Loans, it is all the more important that the neediest students be assured of loan availability.

It is sometimes argued that federal capital contributions may be cut back to reflect increasing institutional contributions to the NDSL revolving fund. This view is mistaken: while it is true that some 600 institutions have reached the point where further contributions to the revolving fund are not needed, 80 percent of the institutions throughout the country would have to cut back on loans if capital contributions were restricted, and the known demand for NDSL loans exceeds $1 billion.

Guaranteed Student Loans (GSL). We acknowledge that additional steps are needed to control the rising costs of the Guaranteed Student Loan Program, and to prevent upper-income families from taking advantage of the in-school interest subsidy. We are working with the authorizing committee to develop some options for controlling costs without destroying the usefulness of this program as a major mechanism for paying for postsecondary education. We believe it may be possible to restrain GSL program costs significantly in FY 82, perhaps by as much as $500 million. Estimates for current law funding needs range from $3.3 to $3.7 billion.

However, the Administration's request of $1.8 billion is totally unrealistic. We support the concept that students should not borrow in excess of their families' realistic needs. However, the Administration's recommendation to accomplish this objective would discourage many lenders from participating in the program and make borrowing too costly for many families by eliminating the in-school interest subsidy for all students. Moreover, according to the Congressional Budget Office, the Administration's proposed need requirement would "increase the program's complexity and reduce lender's yield per dollar loaned because the average loan amount would go down, but administrative costs for each loan would not. These changes would make the program less attractive to lenders, and as a result, some students (particularly needy students, who are generally less-preferred borrowers) could have difficulty obtaining loans." Some 350,000 Pell Grant recipients are also GSL borrowers.

The Administration proposes to eliminate the current option for students to borrow their expected family contribution. Thus, students whose families are unable or unwilling to provide their expected family contribution would be unable to obtain the resources to attend college. Students at public institutions generally would be unable to show "remaining need" of more than a few hundred dollars, and banks would be unlikely to make loans in such small amounts. Students at independent institutions would have more difficulty borrowing because banks would be less likely to make loans with the elimination of the in-school interest subsidy, and would be more resistant to borrowing because of the increased debt burden, which would also tend to increase future defaults. Elimination of the in-school interest subsidy would increase the individual student's debt burden by 25 - 40 percent. In addition, costs to the government will increase because an additional special allowance will have to be paid to lenders to cover the accrued in-school interest, or administrative costs will be increased for lenders who have to collect the interest or discount the note.

In summary, the Administration's recommendations would drastically reduce GSL's effectiveness as a major mechanism for financing higher education. This would be a particularly serious blow for graduate and professional education (which accounts for 25 percent of current GSL volume), leaving graduate students without other means of support outside of personal resources. Small independent colleges, many of which rely on tuition for up to 90 percent of revenues and on GSL for much of their cash flow, would face immediate hardship. This loss of revenue would be devastating to several hundred smaller institutions with large accumulated deficits that preclude their ability to make up losses of financial aid to their students.

We estimate that the GSL changes proposed by the Administration would force 750,000 to 1,000,000 students to change their plans and attend different types of institutions, or drop out of college entirely. This would be a tragic reversal of the commitments Congress has made in recent years to expansion of postsecondary opportunities for all citizens.

Graduate Fellowships. In addition to the programs authorized by Title IV of the Higher Education Act, one other program is of central importance to our priority on student assistance: Title IX of HEA, authorizing graduate fellowships. These are important because they provide for important national manpower needs and because of the pressures which will certainly be placed on the fellowship programs due to expected restriction of Guaranteed Loans. The Administration proposes to reduce these programs to $11 million from the current $14.15 million level. We recommend $20 million to maintain current levels for Graduate and Professional Opportunity Fellowships, and to permit the award of a limited number of fellowships in the social sciences, and the humanities as authorized by the 1980 Amendments.

Also important to the maintenance of postsecondary opportunities are the TRIO programs which provide special services for the disadvantaged to encourage their participation and retention in college. The Administration proposes to level-fund TRIO at $159.5 million. We urge $200 million to make continued progress for these programs as a vital component of the federal strategy to achieve equal educational opportunity.

February 9, 1981

The Honorable Harrison H. Schmitt
Chairman, Subcommittee on Labor-HHS-Education
Committee on Appropriations
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

This is to urge prompt action on supplemental appropriations for FY 81 to avert a critical shortage of student assistance funds this spring, when students make their plans for the 1981-82 college year.

Unless a supplemental is provided, we estimate that the maximum Pell Grant will be cut drastically from the $1800 maximum Congress intended to a maximum of approximately $1250.

Unless a supplemental restores federal capital contributions to the Direct Loan program to the FY 80 level, we estimate that 135,000 students with documented need will be forced out of the program.

If proposed changes in the Guaranteed Loan Program are accepted, hundreds of thousands of students will face immediate difficulties in financing their undergraduate, graduate, and professional education, and many independent institutions will face a serious financial crisis.

Therefore students, parents, and colleges and universities throughout the nation are anxiously awaiting final decisions on funding of these programs for FY 81. Your decisions will determine whether needy students will be able to obtain the assistance that is necessary to meet their college costs. And unless the decision is made by mid-April, in time for the Education Department to issue a payment schedule so that institutions can notify students in the spring of what aid they may expect in the fall, thousands of them will be unable to plan to continue their education.

Following is a summary of each of the issues to be resolved:

(1) Pell Grants. The Continuing Resolution passed last December waived the $1900 maximum authorized by law and set the Pell Grant maximum at $1800 for FY 81, providing $2.159 billion for this purpose. This amount was the estimate included in the Carter Administration's March 1980 budget request. However, the latest estimates now indicate that an additional $627 million will be needed to pay the intended $1800 maximum, as well as an additional $284 million to replace funds borrowed from FY 81 to pay FY 80 awards.

Therefore, unless $911 million is provided in budget authority for the Pell Grant program in an FY 81 supplemental appropriation, funds will be insufficient to pay the $1800 maximum in Academic Year 81-82, and the value of the award will be seriously eroded by inflation and the rising costs of college. Pell Grants were originally intended to meet half of average college costs. When they were funded at $1800 in FY 79 for the Academic Year 79-80, the maximum represented 45 percent of average college costs. Even if Congress were to fund the $1900 maximum authorized for Academic Year 81-82, this would only meet 40 percent of average college costs. An $1800 maximum would meet 38 percent.

Failure to appropriate any funds over the $2.159 billion in the Continuing Resolution would impose a drastic cutback in educational opportunities: the Pell Grant maximum would have to be reduced to approximately $1250 -- 27 percent of average college costs for Academic Year 81-82.

(2) Direct Loans. The Continuing Resolution provided $186 million in federal capital contributions for the need-based Direct Loan program -- a 38 percent reduction from the $286 million appropriated in FY 80. Including the 10 percent institutional matching funds, this represents a reduction of $110 million, which would force some 135,000 needy students out of the program at a time when documented need for these loans exceeds $1 billion.

Students denied Direct Loans would have no recourse to meet their educational expenses unless they are able to obtain Guaranteed Loans. But banks are reluctant to extend credit to low-income families, and the restrictions proposed in the Carter Administration's January 15 budget would effectively eliminate low-income students from the GSLP.

Furthermore, the $100 million NDSL cut would be borne inequitably among the states, because of hold-harmless provisions in the program's allocation formula. For example, Maine would be cut 39 percent, Vermont 34 percent, New Hampshire 32 percent, Massachusetts and Oregon 22 percent, New York 21 percent, and New Mexico 19 percent, whereas Arizona, Kansas and Wyoming would receive 100 percent of their previous year's allocation.

(3) Guaranteed Loans. The legislative revisions proposed in the January 15 budget would reduce the costs of the program by an estimated $137 million in FY 81, and an estimated $878 million in FY 82. These proposals are designed to prevent one million students and parents from borrowing who would otherwise have utilized the GSL or the new Parent Loan program. The proposals include limiting Guaranteed Loans to the amount of remaining need after deducting grant assistance and estimated family contribution, eliminating the federal subsidy paid while the student is in school, and raising the interest rate on Parent Loans from 9 percent to the prevailing market rate.

While such restrictions on borrowing would not work a hardship on families with other available resources, they would heavily burden students from the lowest-income families, such as the 350,000 Pell Grant recipients who had to take out Guaranteed Loans last year to meet their college expenses. Between 30 and 40 percent of Guaranteed Loan borrowers are students at independent institutions; at many independent institutions two-thirds of all students depend on GSL's to meet expenses. Some 25 percent of GSL volume finances graduate or professional studies. Therefore, any sudden restriction of GSL borrowing with a simultaneous cutback of the Direct Loans program would exacerbate the problems of financing a college education for thousands of students and their parents, and create a serious financial crisis at hundreds of independent institutions where GSL's are a substantial portion of revenues.

In view of the complexity of this issue, we believe that the authorizing committees of Congress should hold hearings on ways to control GSL costs without serious disruptions in financing higher education for needy students, and obtain the recommendations of the National Commission on Student Financial Assistance (established by the Education Amendments of 1980 to study this and other issues), before major changes are made by appropriations language. Under the Continuing Resolution, Congress has authorized sufficient funds to meet GSL obligations for FY 81.

This letter is submitted on behalf of:

American Association of State Colleges and Universities
American Council on Education
Association of American Universities
Association of Catholic Colleges and Universities
Association of Jesuit Colleges and Universities
Coalition of Independent College and University Students
Council for the Advancement of Small Colleges
National Association for Equal Opportunity in Higher Education
National Association of Independent Colleges and Universities
National Association of Schools and Colleges of the United Methodist Church
National Association of State Universities and Land-Grant Colleges

National Association of Student Financial Aid Administrators
United States Student Association

Sincerely,

Charles B Saunders Jr

Charles B. Saunders, Jr.
Vice President for
Governmental Relations

STATEMENT OF MRS. ELLIOT L. RICHARDSON, CHAIRMAN OF THE BOARD, READING IS FUNDAMENTAL, INC.

ACCOMPANIED BY RUTH GRAVES, PRESIDENT, READING IS FUNDAMENTAL, INC., SMITHSONIAN INSTITUTION

Senator Burdick. Our last panel will testify on educational research and improvement, so would you please come up here?

Mrs. Richardson, will you be first?

Mrs. Richardson. I am Ann Richardson, national chairman of Reading Is Fundamental. We thank you for letting us testify, and with me is president Ruth Graves, and also in the room are three members of our distinguished national board, Jean Sisco, Sam Eckrich, and Linda Roth.

For fiscal 1982, the administration proposed to consolidate the program into a block grant. Reading Is Fundamental urges Congress to retain this program as a separate categorical grant and not fold it into a block grant, to exempt the program from the 25-percent rescission and for both fiscal 1981 and 1982 to appropriate $6.5 million. A 25-percent rescission now would force this program to serve 600,000 fewer children and to deliver 2 million fewer books. In fiscal 1980, this program received $6.5 million, with inflation, even level funding fiscal 1981–82 represents a decrease in the program's real dollars. With $6.5 million in 1982, the program could serve 2.8 million children, 225,000 fewer, even than they are reaching now.

Even at this amount, we cannot meet the public's demands for this program. In the last 12 months alone RIF had to turn down more than 1,000 communities who wanted to adopt the project. In establishing the program, Congress modeled them on the basic RIF program that had been motivating children to read for more than a decade. By giving children a chance to own books and by involving parents, RIF was making progress against our Nation's serious reading problems.

With the Federal backing, through this inexpensive book program, that progress has now been taken nationwide.

In 4 years the number of local projects grew from 400 to nearly 4,000. Under current law, the Secretary of Education must contract with a single national organization to operate this program. Reading Is Fundamental has been that contractor since the program began. As required by law, RIF subcontracts with local groups providing services, book discounts and Federal matching funds to buy books for children. The nearly 4,000 projects operate in all 50 States, Puerto Rico, Virgin Islands, Guam, and the District of Columbia.

It is designed by and for the community it serves. The projects are run by 115,000 volunteers, 40,000 of whom are parents of school-age children. In 1980, they gave 3 million youngsters a chance to own 11 million books. This program provides a service not given by the schools or by any other organization. Studies show that books in homes result in improved reading levels, and certainly this program is getting remarkable results. Local communities consistently tell us the book program is encouraging children to read more, use the library more and getting parents in communities involved.

Many also report increased reading scores. Studies of these are detailed in our complete testimony. Not only does the program get results, it does so at a remarkably low cost. It costs the Government less than $3 per child per year. This is possibly because of the efficiency of economy. Furthermore, each Federal dollar generates approximately $3 in private funds, goods, and services, 115,000 volunteers donate their funds and services of 7,000 local businesses and civic groups and many services that RIF provides, that is at no cost.

Under the rescission, this factor would be lost. Many factors make it so that this would not work under a block grant. Half of the present projects are operated by private groups, not by schools or other education agencies. The cost to duplicate across 16,000 school districts, the services RIF now provides centrally, would be prohibitive.

I wish there was time to tell you about many of the RIF projects. Each one is individual and each one is created at the grassroot levels. In South Dakota, 20 projects are serving 9,185 children, who distributes 330,028 books annually.

Now I will quickly close by trying to summarize our feelings about these two items. Block granting this program would cost local governments a great deal of money, lose millions of private dollars and cause administrative chaos. We can see no logical reason to take an effective inexpensive program operated by innovative private organizations and submit it to destruction by bureaucracies. We urge Congress once again to maintain this as a categorical program and not to consolidate it into a block grant.

We further urge Congress to maintain the fiscal 1981 budget at the appropriated amount, $6.5 million and again appropriate that amount for fiscal 1982.

Senator BURDICK. Thank you.

How many States have——

Mrs. RICHARDSON. All 50 States.

Senator ABDNOR. You said some States have law prohibiting distribution of books.

Ms. GRAVES. There are a number of States that have such laws. We have not got the number, the cost of investigating all 50 States.

Senator ABDNOR. Even though there are laws on books, I take it, Mrs. Richardson, you are convinced the States would ignore the program; is that what you are saying?

Ms. GRAVES. Among other things, by dividing the money across the States—we now have 4,000 programs and by dividing it among the 16,000 LEA's, you would so narrow down the amount of money available, plus the fact that it would be consolidated with some 40 other programs going to the LEA's, and one of the major concerns—we have two major concerns. One of them is that 50 percent of the programs are operated by groups outside of the school systems altogether. And obviously school systems would have to give further priorities to their ongoing school system-operated programs.

Second, because of these State laws, like I mentioned, a few of the States, Illinois, Ohio, Pennsylvania, Virginia, are a few we know about from experience that we have had with them, do have these State laws which prohibit use of education moneys to purchase books to give away. There is a law against—there is such a law in many of the States.

Senator ABDNOR. Thank you.

Mrs. RICHARDSON. May I make one further comment? We also feel having one single national administration, that administers all of these 4,000 local programs is much more efficient. We have a staff of 50 that does all of that work, which is backed by volunteers. If you divided it among 50 States, which is not what is proposed, but the local education authorities, it would more than double the staff just to even do the paperwork for the program, and it wouldn't have the expert services that our staff does.

Senator ABDNOR. Thank you very much. Your complete statement will be made part of the record.

STATEMENT OF DR. EVERETT D. EDINGTON, DIRECTOR, EDUCATIONAL RESOURCES INFORMATION CENTER CLEARINGHOUSE ON RURAL EDUCATION AND SMALL SCHOOLS, NEW MEXICO STATE UNIVERSITY, LAS CRUCES, N. MEX.

Mr. EDINGTON. I am Everett Edington, director of the Educational Resources Information Center, Clearinghouse on Rural Education, and professor of education management in New Mexico State University.

I would like to express my appreciation at the opportunity of sharing my views on the role of the Federal Government in research and improvement programs. One of the basic functions of the Federal Government in education is that of providing information to the local and State education agencies on making decisions, solving their own problems at those levels. That is the major purpose of the information dissemination at the Federal level, and that of providing that information.

I would also like to recommend for increased efficiency, and I think more effective research programs that the Federal Government develop cooperative research programs with the States, utilizing the expertise found in the States and local university scattered throughout the land. This is also an aid in having research programs closer to where the problems are generated and where the research could be utilized.

I would like to briefly talk about two dissemination programs. The first of these is the resource information center, an area I am talking about, and the National Diffusion Network and now ERIC has over 700 libraries over the Nation. The role of the Federal Government is collecting abstract information and putting it in formats that can be used by the local people.

Some of the latest information which I received yesterday, there is a study that is being processed by the NIE, which will show that approximately 20 percent of the resources in an area comes from the Federal Government and that 80 percent comes from the local districts, the States, and the other local agencies to purchase the collections.

I would strongly recommend that this system continue, because it is the type of system that if millions of more people started using ERIC system, it wouldn't cost the Federal Government a dime.

I do recommend the $5.5 million be appropriated for 1981, and $6.5 million to be appropriated for 1982. The national diffusion network is a program which shows exemplary educational practices throughout the United States. Resources for the developers and teachers from other classrooms can share their programs and successes.

A good example would be if an elementary teacher in Vermillion had a specialized reading problem, he could go to the State network and maybe they could find a school that had solved the problem effectively and bring these people to Vermillion to solve the problems. I think this is an effective partnership between the State, local, and national.

I do recommend for continuing that program that there be $14 million in 1981 and $16.5 in 1982.

One last comment. I do have a strong interest in rural education. I feel that the Federal Government and the Department of Education should spend more emphasis and return on dissemination areas. I would like to commend the National Institute of Education for its continued support of the Clearinghouse on Rural Education in the past few years.

Thank you.

Senator ABDNOR. Thank you.

STATEMENT OF DR. EVA L. BAKER, CEDAR BOARD OF TRUSTEES, COUNCIL FOR EDUCATIONAL DEVELOPMENT AND RESEARCH

Ms. BAKER. I am Eva Baker. I run an R. & D. center at UCLA, and I would like to talk for the next few minutes about how educational research has impacted practice. Our center studies evaluation information utilization, principally tests and evaluation of educational programs, and we are interested in looking to see how tests and evaluation may improve the quality of education practice.

Testing is a well-known national problem. And we feel that there is some difficulty in interpreting meaning of test scores, and especially achievement test scores. There is enormous popular belief that adding more testing to schools will increase quality of educational programs, and there is a similarly large investment of public funds. Our low estimate is around $100 million a year in the purchasing, scoring, and interpreting of achievement tests. Our center takes a neutral position about tests and tries to maintain objective perspective. Testing the actual quality and looking at the way tests are used in schools. One of the projects that we have completed, involved reviewing all commercially available achievement test scores and looking at their technical as well as practical areas.

Incidentally, our findings were quite negative. The second kind of study that we are in the midst of, is looking at the test use in classrooms to see how much time, what kinds of tests and what kinds of benefits tests accrue for students.

We have only preliminary results right now, but I think there are four findings that are interesting. One, there seems to be a narrowing of the curriculum to the manners that are undergoing testing, particularly using signs and for even language instruction.

Second, tests take a good deal of time. In some States we hear that the month of May is foregone and given over exclusively to testing.

Third, that there is a paradoxical effect of tests where the disadvantaged learners are often tested most and, therefore, instructed least, which we seem to think has some important predictive value.

And last, that while everybody thinks tests are a good idea, nobody claims to use them. Teachers think principals use them, principals think the school district uses them, the school district doesn't have any direct use for them. They are assured they are valuable to the teachers.

We have developed some alternatives to tests, and we are hoping to continue that work. We believe that tests ought to be public. They ought to be relevant to instructions. They need to be economical, and they need to be fair. We have also conducted work on writing and the quality of students' written composition, and I assume you are as appalled as we are by the quality of students' writing that is available.

I will give you one example, and stop. We are concerned with why students can't write and did a study of high school composition classrooms to see what English instruction was like. And we found that the average number of writing assignments given to students was one a month, and the average length was one page. So there was no surprise for us why students were not writing.

We are continuing that effort, and I thank you for the time to listen to me.

Senator ABDNOR. How long has this testing program been in existence?

Ms. BAKER. Since 1967. But we have been focusing on different aspects of testing over that period of time. The most recent work, the national study on test use began last year. We are collecting data from 100 school districts, rural and urban, in all regions, and we expect to analyze the results and present policy findings next year.

Senator ABDNOR. Do you find most of the schools are using your services?

Ms. BAKER. Well, we don't directly provide services to all schools, but we do work with some schools in helping them try to find alternative ways to test students, so that teachers can make better use of the information, and we have been quite successful in that area.

Senator ABDNOR. Thank you all very much. I appreciate you coming to testify. Your complete statements will be inserted in the record.

Thank you very, very much.

[The statements follow:]

STATEMENT OF MRS. ELLIOTT L. RICHARDSON

BLOCK GRANTING WOULD TRANSFER PROGRAM FROM PRIVATE TO GOVERNMENT CONTROL

The Administration has proposed that a program operated by one private organization be transferred to 16,000 local governmental agencies -- a notion that runs contrary to any model of efficiency or any theory of less government involvement.

In establishing the Inexpensive Book Distribution Program, the Congress saw the importance of bringing the private sector into the education of our children. Congress created a program that works in harmony with, but is not operated by, traditional educational institutions.

The Congress provided funds for this unique, private nationwide effort that succeeds precisely because it is privately operated and it is nationwide.

Now the Administration proposes to splinter that highly successful private program among 16,000 local bureaucracies.

The Administration proposes to do this in FY 1982 by consolidating the Inexpensive Book Distribution Program (IBDP) with other programs in a block grant to local education agencies. If Congress does include the IBDP in a block grant, the net effect will be to lose the program.

The Administration also proposes a rescission of 25% of the $6.5 million appropriated for the IBDP for Fiscal 1981, a reduction that would mean more than 600,000 children could no longer participate in the program.

PROGRAM MEETS CRITICAL NEED - AT LOW COST

The Inexpensive Book Distribution Program addresses a critical national problem -- the declining reading abilities of America's children -- with services and a unique method not provided by the schools or any other organization. Around the country, the program is motivating children to read, involving thousands of parents and other citizens, and attracting massive private support to the national reading effort.

It is doing so at very little cost to the government -- less than $3 per child, per year.

This is a program we can ill afford to lose.

BLOCK GRANTING WOULD ELIMINATE THE PROGRAM

Yet it would be lost if consolidated in block grants. The cost of duplicating in many local schools what is now provided centrally would be prohibitive; intervening laws in many states would make it inoperable; and the government would lose the private dollars, volunteers and the services that the federal funds generate.

READING IS FUNDAMENTAL RECOMMENDATION

Reading Is Fundamental recommends that the Inexpensive Book Distribution Program be retained as a categorical program, and not consolidated in a block grant.

RIF further recommends that the IBDP be exempted from a Fiscal 1981 rescission and that in Fiscal 1982 it be retained at the current level of $6.5 million.

HOW THE IBDP BEGAN

RIF began in 1966 with a brilliantly simple idea -- motivate children to want to read by letting them choose, and keep for their own, books that interest them. With support from private business and local citizens, RIF set about creating grass-roots projects that soon spread to communities around the country.

By 1975 RIF's results were so impressive that the Congress determined that the program should have the federal backing necessary to achieve national results. Congress thus created the Inexpensive Book Distribution Program, modeling it directly on RIF.

HOW THE IBDP PRESENTLY WORKS

Section 231 of the Elementary and Secondary Education Act requires the Secretary of Education to contract with a national organization to operate the Inexpensive Book Distribution Program.

The U.S. Department of Education contracts with Reading Is Fundamental to operate the program.

RIF, under the terms of the legislation, then subcontracts with non-profit groups (such as business and service clubs) and public agencies (such as libraries and schools), providing them with program guidance, negotiated book discounts, and federal matching funds, which they use solely to buy books for children.

Today there are 3,800 local projects operating in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Guam. In 1980 they brought 11 million books to three million young people, age pre-school through high school.

Some 115,000 private citizens volunteer with the projects. Nearly 40 percent are parents.

BLOCK GRANTING WOULD DESTROY THIS EFFECTIVE PROGRAM

In these days when the country is striving to revitalize our underproductive economy, the literacy of our potential workers, our children, must be a national priority.

Unlike most of the education programs being consolidated, this program is not predominantly school-based and school-operated. It is a grass-roots program that relies on parents, volunteer citizens and private business and service groups.

We estimate that under the block grant at least 85% of the projects would almost automatically be lost, 2.7 million children would not be served, and 8.8 million books would not be distributed.

Many factors make it impossible for this program to survive under a block grant:

- Many states and localities have laws specifically prohibiting use of education funds to buy books to give away.

- The cost to duplicate, across 16,000 school districts, the services now centrally provided by RIF would be prohibitive.

  Example: RIF centrally negotiated substantial discounts with 323 book suppliers -- discounts that apply to RIF projects nationwide.

- The RIF book discounts are from 5% to 25% greater than those the same suppliers give schools. Most books are now purchased with an average RIF discount of 41%

  Thus the number of books which could be purchased would be drastically reduced.

- The local IBDP projects could not compete successfully for funds with other programs in the block grant.

  Projects are now operated by 115,000 volunteers, most of whom have no formal connection with the school systems. They have no staffs, no offices, no administrative funds that would enable them to mount the campaign necessary to make their case before the education agencies.

- Half of the present IBDP projects are operated by private groups, not by schools. These are libraries, voluntary service organizations, parent groups, child care centers, hospitals and others.

- 90% of the support in volunteers and funds now comes from non-school sources.

- The local match (25%) would be eliminated -- thus further reducing the amount available for books.

- No federal funds are now provided to administer the local projects. If the schools elected to adopt the program under the block grant, they would have to find the administrative funds to operate it.

We know of no other program proposed for block grant consolidation that requires a matching cash fund rather than in-kind contributions.

Further, if the object of the "Economic Recovery Program" is to reduce spending, then it must be noted that it is far less costly to leave this program centrally funded.

THE PROGRAM ADDRESSES A MAJOR U.S. CONCERN: THE DECLINE OF READING ABILITIES

There can be no question that functional illiteracy is an endemic problem in this country, and we will not cite all the mounting evidence this Committee knows well.

But we would emphasize:

- That reading problems add $6 billion each year to the nation's welfare and crime costs, according to a 1972 study made for the U.S. Senate.
- Out of 600 companies surveyed in 1976 by the Conference Board, 35% found it necessary to provide employees with remedial instruction in basic skills.
- 95% of 17-year olds in the Soviet Union graduate from high school. In the U.S., 75% graduate and close to 15% of them are functionally illiterate.

IBDP IS GETTING CHILDREN TO READ

Study after study has shown that motivation and books in the home are vital keys in getting children to read.

This program is putting those keys in the hands of local citizens. Some preliminary analysis of information spontaneously volunteered by local projects shows that:

- 67% report that the children are developing more positive attitudes toward reading.
- 76% report that the youngsters are spending more time reading than they did before the RIF project began, and
- 87% say that parents are actively involved in the RIF reading activities.

In 1978, studies by the state departments of education in Texas and Pennsylvania revealed that, in grades 5, 8, and 11, students who had books in their homes scored higher on the reading test than students from homes without books.

Reports on both studies credited RIF's important role in improving students' reading skills.

In 1980, researchers from the California State University, Sacramento, documented that RIF significantly improved the reading attitudes of 154 elementary school children -- after only 16 weeks of activities.

There are numerous specific examples of this program's results, which this Committee will see when we provide each member with information from people in your home states.

From Fargo, North Dakota, for example, we hear from a reading consultant who says library circulation in her school has tripled.

A superintendent of schools in Maine reports that pre- and post-RIF tests show that reading scores are rising.

From an inner-city Chicago school, the PTA reports that reading scores are so high that parents from other neighborhoods want to transfer their children to the school that, before RIF, was known as the "Dummy School."

WHAT THE GOVERNMENT NOW RECEIVES FROM ITS INVESTMENT, AND WHAT WOULD BE LOST UNDER THE BLOCK GRANT

For every $1 the federal government appropriates for this program, Reading Is Fundamental and the local projects now contribute $3 in private funds, materials and services.

Under the block grant, all this would be lost:

- The services at no cost to the government of 115,000 volunteer citizens, 40 percent of whom are parents.
- The donated funds and services of more than 7,000 service groups, private businesses, and other private groups.
- The RIF book discounts. Most books are purchased, through RIF, at an average discount of 41%.
- Activities and materials produced by Reading Is Fundamental with private funds, such as a nationwide reading emphasis day for IBDP projects in 1979, and a film on reading, made available to projects at no cost.
- Free books that RIF encourages publishers to donate to IBDP projects in needy communities -- 550,000 in the last 12 months alone.
- Funds that RIF obtains from corporations to pay the local matching share of book costs for IBDP projects in needy communities.
- A public education campaign to promote reading that RIF sponsors with private funds. The public service announcement featuring actor Edward Asner received $4 million in free, donated broadcast time from the television networks alone in 1980.
- The efficiency and economy of administering 3,800 projects through a private, nonprofit organization that provides economy of scale through centralized services. A recent independent study contracted for by the Department of Education credited RIF's "effective and efficient" management of the IBDP.

ADMINISTRATION'S REASONS FOR A BLOCK GRANT DO NOT APPLY TO THE IBDP

The Administration justifies the block grant approach as an attempt to shift control over education policy away from the federal government and back to state and local authorities.

IBDP programs are already designed by and for the local communities they serve. All important decisions -- which children to serve, what books to buy -- are made by local citizens.

The Administration says existing multiple requirements are burdensome, inflexible, unresponsive and duplicative.

The IBDP has no multiple requirements or complex regulations, and paperwork is minimal. The program is simple and streamlined, making it easy for busy citizens to volunteer their time.

The Administration states that block grants would end byzantine squabbles over myriad accounting regulations which aid bureaucrats, not children.

In the IBDP there are no accounting regulations for IBDP projects, because they never handle federal funds. RIF makes all the payments of federal funds, and absorbs all paperwork and accounting tasks in its central office.

WHY BUREAUCRATIZE AN EFFECTIVE PROGRAM?

Block granting this program would cost local governments a great deal of money, lose millions of private dollars, and cause administrative chaos.

We can see no logical reason to take an effective, inexpensive program operated by an innovative private organization, and submit it to destruction-by-bureaucracy.

We urge the Congress once again to retain the Inexpensive Book Distribution Program as a categorical program, and not consolidate it in a block grant.

We further urge the Congress to maintain the FY 1981 budget at the appropriate amount of $6.5 million; and to again appropriate $6.5 million for FY 1982.

STATEMENT OF DR. EVERETT D. EDINGTON

RESEARCH AND IMPROVEMENT

The major purpose of the federal government's involvement in education should be to provide states and local districts with those services that they cannot provide more efficiently for themselves. I firmly believe that the responsibility for curriculum selection, program operation and those activities related to such decisions belongs with the states and local districts. There are three major functions which can best be performed at the federal level. These are: (1) research and development; (2) dissemination; (3) certain types of technical assistance.

Research and Development

A continual argument in most academic areas relates to the role of basic versus applied research; I would like to quote from a recent article in the February 1981 issue of Science. This is by Federick Mosteler, discussing the importance of different types of research. He says, "It seems clear, however, that both mission- and nonmission-oriented research are important, and the nonmission work goes on generally well in advance of the mission-oriented research, which in turn tends to precede the development work." Educational research is no exception. It is important that basic as well as applied research be an integral part of the research agenda of the federal government. Adequate safeguards should be taken that neither one gets a disproportionate share of the resources and that those with decision-making responsibilities for the allocation of research dollars be aware of these restrictions. This is not to say that allocations should be even. I believe that the majority of funding should probably support action-type research and in turn the development of educational materials for use in the states and local districts. This can be done at the federal level much more efficiently and with less duplication of effort than at state or local levels.

However, this research should be done cooperatively with the states, and with the universities and other agencies capable of doing such research within the states. The federal government should engage in research efforts only with those institutions and agencies that have expertise and a history of research in a particular area. It should be a cooperative effort, the federal government should not be expected to provide 100% financing. Thus those universities that are already committed to certain types of research could use federal money much more efficiently in furthering these research efforts than in using federal money to tool up from the beginning for specific research activities. Resources allocated from the federal level are more likely to make a difference if they are used for research performed by those people and agencies near to the classroom teacher, who knows and trusts these researchers.

Dissemination of Research and Development Results

The Department of Education should see dissemination of information as one of its major functions. It should provide information in a usable form to those persons in state and local districts who have decision-making responsibilities; this would be a logical extension of the research efforts. There is a long history of successful programs in both research and dissemination of information in the area of agriculture, with the agriculture experiment stations and the extension services. A similar dissemination of educational information would not only aid in making available the results of research developed at the federal level, but could also act as a means of spreading the information from one state to another. This could help to avoid costly duplication of educational research programs. A number of components should be included in any successful educational information dissemination system:

1. Database. The National Institute of Education has in operation the ERIC system which provides a broad database for those persons involved in education in the nation. It includes information which can be used at state and local levels, and within the classroom itself. The ERIC operation at the federal level should be increased, to assure that such information is available for those in the states and local districts.

2. Analysis and interpretation of research and resource information. There is nothing more frustrating for the busy educational administrator than to contact his state department of education or other linking agency, ask for information, and be given a large pile of documents related to his problem. Many do not have the time or expertise to make the analysis necessary and to develop that information which would help them solve their problems. Therefore, the analysis and interpretation of research information is an extremely important federal responsibility and should be a part of the dissemination thrust. It is important that inforamation be in the proper form for those who have to use it to solve their local problems.

3. Linking function. It is important to have a linking agency between successful programs and those schools and districts who are looking for information and programs to solve their particular problems. The National Diffusion Network has been an excellent example of how this type of program can be extremely successful in helping provide this sort of proven information to schools throughout the nation. In addition to utilizing databases such as ERIC, the National Diffusion Network also utilizes the expertise of people who have been successful in their particular educational endeavors. Such programs are identified, evaluated and brought to people who are in need of help in solving their own problems. This service should be broadened. State facilitators in the

National Diffusion Network should have additional resources to enable them to go to different databases and to coordinate their efforts in helping the people at the state and local level solve their educational problems.

4. Coordination. For the dissemination systems to be successful, it is extremely important that there also be a network of those persons and agencies involved in the dissemination system. At the federal level there should be a much closer coordination of agencies involved in transmitting educational information to state and local people. The federal government should give strong consideration to putting these major dissemination agencies into one administrative unit. If the dissemination function is spread through several units in the Department, quite often it will take a back seat to some of the other functions.

5. Evaluation. The dissemination system itself should include an integral, on-going evaluation system. This evaluation should not be developed only by dissemination experts, but there should also be heavy involvement of the states and local districts that the program was developed to serve. Continuous input from the state and local districts would insure on-going improvement of the system.

Technical Assistance

A limited technical assistance program must be provided to the states to help them solve the problems which they are able to identify. It is important that these problems be self-identified, and that it not be the federal government making decisions on what problems each state or local district may have and coming up with solutions for them. This technical assistance must be closely related to the dissemination of information, as well as to the research and development functions. One of the major purposes of such a technical assistance program will be to identify people or agencies within the states who may be of service to others, rather than having the federal government see itself as knowing all and being able to answer any questions which may arise at the state level. Again, this technical assistance may be much more useful in a facilitator role than as direct assistance.

RESEARCH AND IMPROVEMENT IN RURAL EDUCATION

There is an increasing awareness of the neglect of education in rural areas. Not all of the problems associated with rural neglect and inequities are necessarily federally-caused, nor are they necessarily amenable to federal remedies. State policies contribute to much of the rural burden. Most federal policies involved with education have been directed toward the problems of the urban and suburban schools. The neglect of rural schools has not been intentional, but has come about through the failure of those in federal decision-making positions to recognize the unique problems of education in rural America.

I would like to make the following recommendations relative to the role of the federal government for research on education in rural America:

1. Research should be recognized as a national responsibility, and the research programs of the National Institute of Education and other agencies in the Department of Education should look at the needs of rural schools as well as those of urban and suburban schools.
2. The dissemination and distribution of research findings should be done by a national network; this would include research-generated information helpful to the states and the local schools in their decision-making responsibilities. The ERIC Clearinghouse on Rural Education and Small Schools at New Mexico State University is an extremely important part of the ERIC network, funded by the National Institute of Education. The network of ERIC clearinghouses across the nation should receive adequate support to carry out their vital function. In addition, successful practices should be identified, validated, and disseminated on a national basis and stronger ties be made between ERIC, the National Diffusion Network and other dissemination agencies in the Department of Education. Some rural schools have dealt successfully with their problems and it is hoped that these solutions could be shared on the national level. The National Diffusion Network should be strengthened to carry out its important work, and should be directed to make sure that it is serving the rural school within its program.
3. There should be planning of an extension service model which could be developed within two or three states with federal assistance, and then transported to other states to be adapted to their particular needs. This should recognize the needs of the rural small schools and might be an educational equivalent of the successful agriculture extension service.

Again, I would like to emphasize that decison-making responsibilities should lie with the state and local districts. However, rural education has been neglected and there are some functions which can best be performed at the national level. It is hoped that the Department of Education will take a good look at itself and determine which of these functions could best be done from the federal arena, to make sure that rural America is not neglected in its educational needs.

STATEMENT OF EVA L. BAKER

The Council for Educational Development and Research (CEDaR) is pleased to have this opportunity to appear before the Senate Appropriation Subcommittee on Labor, Health and Human Services, Education, and Related Services. We appear here in support of appropriations for the National Institute of Education (NIE), an agency operating as part of the Department of Education's Office of Educational Research and Improvement.

Colleagues of ours from the larger educational associations have made the case before this Committee on behalf of the total federal budget for education. We stand with them in urging the Committee to examine closely the impact of the proposed education cuts. Any funding reduction that reduces the quality of education offered in our schools is shortsighted. The country doesn't save anything by neglecting the education of its youth.

Nor does the country benefit from a reduction in the funds allocated to research and development. And yet the Administration proposes a drastic 25 percent reduction in the FY82 budget of the National Institute of Education. We strongly urge the Committee to maintain the Institute at level funding -- $74.1 million-- in FY 82. Although we believe NIE should receive a funding increase next year, we temper our desires with a sense of realism and humbly request level funding.

The Administration says ". . .while basic educational research has value, deferrals and stretch outs of work currently underway can achieve significant budgetary savings without reducing the ability of the NIE to support improvements in current educational practice" (America's New Beginning: A Program for Economic Recovery). We question just how much "significant budgetary savings" are being gained. But more important, we strongly reject the view that research can be deferred or stretched out without reducing the ability of NIE to improve current educational practice. Research, development, dissemination, and technical assistance in education are integral activities. Starve one function and very soon the others wither.

Labs, Centers Do School Improvement

Before we go any further, we should explain to the Committee our vested interest. The Council for Educational Development and Research has as its charter members the regional educational laboratories and the university-based educational r & d centers. Together, the 17 labs and centers receive roughly $32 million in funding from NIE.

The labs and centers do the kind of the work the Administration supports. That is, the labs and centers do applied research and development. The results are designed to have an impact on student achievement. The labs and centers are not cloistered ivory-tower institutions tucked away doing esoteric research on subjects that grab headlines only when Senator Proxmire issues his award for waste and inefficiency. No, the labs and centers conduct practical, school-focused research and development and carry out a set of activities designed to ensure the practical application of their work.

The Congress created these 17 institutions to do this practical kind of educational r & d. Last year a congressionally created Panel for the Review of Laboratory and Center Operations submitted its final report to the Congress. And the report verified to this body that the labs and centers conduct high-quality work that has an excellent chance of improving the practice of education.

The NIE recognizes the worth of labs and centers. Each currently has a three-year negotiated contract or grant with NIE to carry out an integrated program of educational r & d. The Committee might be interested in knowing how this work was selected.

Federally Funded, Locally Determined R & D

Generally, NIE identifies the work to be performed and then selects a contractor to do it. This procurement practice is used by most government agencies for purchasing everything from office desks to technical services.

The Congress instructed NIE to use a different approach in its dealings with the labs and centers, though. The Congress said that the institutions, not the government, should set their r & d agenda. Furthermore, these institutions should be guided in their r & d work by the needs of the schools they serve.

This federally funded and locally determined r & d approach has worked out quite well. The labs conducted a variety of needs sensing activities within the geographical regions they serve. Based on these assessments and the concurrence of their independent boards of directors, the labs submitted a three-year scope of work to NIE for its review. The centers operate a little differently. Each is located at a major research university. Each has recruited the finest minds available from a wide range of academic disciplines to work as a team on a single educational problem area.

The centers and labs submitted their proposals to NIE in 1980. The Institute, in turn, conducted a vigorous review of the proposals and eventually negotiated a dollar award for each institution. These range from about $750,000 a year to a high of about $3,500,000.

Currently the labs and centers are in the middle of their negotiated three-year awards. An appropriation of $61 million would enable the Institute to honor these existing contractual obligations. But $61 million wouldn't enable the Institute to begin anything new.

The labs and centers, then, have a vested interest in NIE. But so does this Committee. An r & d agency such as NIE exists for one reason only and that's to provide better answers to questions that puzzle us all. For example, we all have a problem when kids leave school not knowing how to read or write. It's much too simple to blame the problem on the schools. But the schools nevertheless are the institutions with the responsibility for educating our young people. So the question becomes, what could they have done to give these nonlearners an adequate education? The research community doesn't have the answer. Certainly not one single answer. But we certainly know a lot more today than we did say three years ago about how schools might go about reducing this problem. For example, the labs and centers have started working closely with teachers on their classroom management skills. Some of the research coming out of the labs and centers has shown us that children make significant increases in achievement when taught in a well-managed classrooms. The task now is to work with teachers to provide them with the skills needed to better organize their presentations and thus take advantage of these new research findings.

R & D As An Approach

A good many people, and certainly some in the current Administration, view educational "research" as something that occurs in isolation from educational "improvement." Frankly, a lot of people engaged in educational research argue that the activity is independent and worthy of support on its own merits. We don't make that argument. We view research as one piece of our overall school improvement thrust.

In other words, we view ourselves as educational problem solvers. Frequently we have a solution. When we do, our task becomes one of providing the school districts with the help they need to apply the solution to fit their local situation. But other times we simply don't have the answer. Frequently we'll have a hunch based on previous research. But that's frequently all it is, a hunch.

For example, the research community has many hunches about how to best teach kids to comprehend or understand what they read. But in all honesty, we don't know the best way of doing it. So while we help school teachers choose among the best options available, we are also conducting research to advance our own knowledge base. Hopefully, we'll be able to provide the teachers with better information next year. Eventually, then, we should be able to develop a solution to this problem as we have for other ones.

Education Needs a Strong R & D Agency

We've tried to make the case that the Administration's rationale for reducing NIE's funding is invalid. Cutting back on the research activities fund while insisting that school improvement occur makes little sense. As the labs and centers continue to demonstrate, the research, development, dissemination, and technical assistance functions are interrelated. One, or two, or all of these activities may be required to resolve an educational problem. We know, for example, that simply providing schools with the results of research outcomes does little to improve their performance. We also know that providing technical assistance to schools that isn't built upon a solid research base is impractical and frequently counterproductive.

Consequently, we urge the members of this Committee to appropriate NIE at least as much money as you saw fit to provide it last year. We cannot speak for the agency, of course. But as a network of institutions with a large share of NIE funds, we pledge to use these scarce resources efficiently to demonstrate to you, and to the education profession, that educational research and development continues to be a sound investment.

SUBCOMMITTEE RECESS

Senator ABDNOR. The subcommittee will stand in recess until 9:30 a.m. tomorrow morning, when we shall continue to receive testimony from outside witnesses.

[Whereupon, at 3:10 p.m., Wednesday, March 18, the subcommittee was recessed, to reconvene at 9:30 a.m., Thursday, March 19.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

THURSDAY, MARCH 19, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:30 a.m. in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Warren Rudman presiding.

Present: Senators Rudman, Specter, and Burdick.

NONDEPARTMENTAL WITNESSES

SUBCOMMITTEE PROCEDURE

Senator RUDMAN. The subcommittee will come to order.

This morning we are going to conclude the public witness testimony on the related agencies. We are going to begin with a panel on the Community Services Administration and conclude with a panel on the Corporation for Public Broadcasting.

Let me say that we appreciate very much your all being here this morning. Let me apologize to you for the limited time which we are forced to operate with. Because of the change of administration, and a major change in the budget as submitted by the previous administration, it's been necessary for this subcommittee, as well as other subcommittees of the Appropriations Committee of the Senate, to go through an enormous amount of data in a very compressed period of time and thus, this morning, each panel will be limited to approximately 15 minutes. We will let you divide that time as you wish.

I can assure you that the staff and members of the subcommittee will look very closely at the statements you submit for the record and the statements you make here this morning. We are going to have the first panel on the Community Services Administration programs. Dr. Warren K. Giese is here representing the National Collegiate Athletic Association. He's accompanied by Archie Griffin of the Cincinnati Bengals. He may find carrying the ball around here tougher than it might be in Riverfront. The other panelist is Francisco Castellanos, National Representative of the National Association of Farmworker Organizations.

Gentlemen, if you would like to come forward. Do we have someone else that I've missed? You bring the rest of your panel forward and if you would introduce the panel, Mr. Giese, we would appreciate it.

STATEMENT OF WARREN K. GIESE, CHAIRMAN, NATIONAL ADVISORY COMMITTEE, NATIONAL YOUTH SPORTS PROGRAM, NATIONAL COLLEGIATE ATHLETIC ASSOCIATION

Mr. GIESE. Mr. Chairman and members of the subcommittee, I am Dr. Warren Giese, professor at the University of South Carolina ~~and~~ chairman of the National Youth Sports Program National Advisory Committee. Also with me here today to speak in favor of appropriations for the NYSP is Archie Griffin, to my left, of the National Football League, Cincinnati Bengals. He's a businessman, twice winner of the Heisman Trophy and three times All-American, but more importantly than all, a former participant and instructor in the national youth sports program at Ohio State University. We are also accompanied by Dr. William Bradley, chief evaluator of the NYSP. At the end of the table, Mr. James H. Wilkinson, assistant executive director of the National Collegiate Athletic Association and national program director of the NYSP. Next to him is Ronald A. Bond, director of recreation at the University of Pennsylvania and a local NYSP project administrator; and Mr. Gregory Stephens, a young man from west Philadelphia who was a NYSP participant and is now a senior, first-year dental student, NYSP program aide and member of the varsity track team at the University of Pennsylvania.

I'm making this statement in support of appropriations for the national youth sports program and with your permission I would like to have inserted in the record a fact sheet which describes some of the accomplishments of this program.

Senator RUDMAN. We will insert all of your statements in the record, after your oral presentations, there being no objection, and certainly we would like you to summarize your statements in the most concise way that could be done.

Mr. GIESE. There are significant reasons for continuing a Federal role in funding this program. For the past 12 years the national youth sports program has been a highly successful program that has served as a link between needy youngsters living in many of the poorest urban and rural communities in our Nation and the positive environment of nearby colleges and universities.

This program has played an important role in promoting good community relations and has helped to direct the energies of young people into constructive channels and to turn youngsters away from destructive behavior patterns.

Second, the Federal dollars used in this program have served as a magnet for attracting the kind of voluntary efforts most of us favor. Consistently, more than $1 in private contributions has matched each Federal $1 appropriated to this program. In fact, the organization which administers the NYSP, the National Collegiate Athletic Association, administers it free of charge at their expense and at no administrative cost to the Federal Government.

This program annually serves about 50,000 boys and girls 10 to 18 years of age, mostly disadvantaged youth, including the orthopedically handicapped. We just started some special programs for them. Over 90 percent of the NYSP participants meet the poverty income guidelines established by the Community Services Administration.

In using the motivating power of sports, these 50,000 young people are attracted to the campuses of over 135 colleges and universities in 40 States. The national youth sports program isn't a hit-or-miss play and recreation program. Rather, it's a highly structured effort to meet head-on the problems which plague disproportionately minority and disadvantaged youth. Health problems—every youngster in this program receives a free physical with necessary followup if indicated. Nutrition—every youngster receives a USDA well-balanced meal a day. Drug abuse, career, and educational opportunities—these are subjects dealt with in the enrichment program which is an integral part of the national youth sports program.

Some of the outstanding resources are role models such as Archie Griffin, Gregory Stephens, and hundreds more just like them who work daily in the NYSP program.

Finally, I want to emphasize a point of most immediate concern. The appropriations for this summer's NYSP under the continuing resolution enacted by Congress has been deferred by the administration until June 30, 1981. Unless this deferral is ended or 1981 funds are otherwise appropriated for the program, the NCAA will not be able to operate the NYSP this summer.

Therefore, we come before you to ask that the 1981 funding crisis be resolved. In addition to seeking an appropriation for fiscal year 1982, without Federal support the NYSP program, with its 12-year history of success and as it now exists, will not survive.

Senator RUDMAN. Thank you, Professor. Mr. Griffin.

STATEMENT OF ARCHIE GRIFFIN, NATIONAL FOOTBALL LEAGUE, CINCINNATI BENGALS

Mr. GRIFFIN. Thank you.

Let me first of all give a little background about myself. I come from a fairly large family out of Columbus, Ohio. I have six brothers and one sister. My father and mother, they didn't get a college education but it was always something that they wanted all of us to have. My father had two jobs to support the family, but even with those two jobs it was difficult for him to send eight of us who were closely together in age to college. We liked athletics and we felt if we were good enough at athletics we could maybe win a college scholarship and take the burden off our parents of sending us to college.

This is where the national youth sports program comes in for us, myself and my three brothers and sister. Raymond, who's a teammate of mine with the Cincinnati Bengals and also has a degree from Ohio State University, and Duncan, who graduated from Ohio State University with a degree in accounting, and Keith, a student at the University of Miami in Florida, and Crystal, who is a sophomore in high school right now; all of us have either participated or helped in the instruction of the Ohio State youth program. This program means a great deal to us because it gave us the opportunity to rub elbows with coaches and outstanding athletes who encouraged us to set goals for ourselves and to also reach those goals.

I remember my sister, Crystal, who when she first entered into the program she didn't have any interest in sports at all. She all of the sudden picked two activities to participate in and one of these activities happened to be track and when she participated in this track she found out that she had a lot of ability in this, and then through her junior high school years she found out she was one of the outstanding girls in track and now she's doing extremely well in high school.

Myself, as an instructor in college, it gave me an opportunity to give something back to the community. I learned a lot from Ohio State University and I had that opportunity to give it back to the community from which I came.

I would like to see the Federal Government continue to support the national youth sports program for a number of reasons.

First of all, it provides participants an opportunity to learn important lifetime skills such as competition, teamwork, and learning to get along with others. It educates young people in drug abuse and alcohol abuse and these are things that we all need to deal with in the real world. It also, as I mentioned earlier, provides contact with college coaches and colleges that have outstanding facilities that the young people can use and these instructors instruct and motivate young people to not just participate in sports but also to be somebody.

This program provides the physical checkups for these youngsters, checkups that these youngsters probably would never receive if it weren't for this program. It also provides a USDA-approved meal each day for the participants and these meals are meals that for some of these participants is probably their best meal of the day and for some others it's probably their only meal, and that is important that they get a meal. It also provides a constructive outlet for youthful energies. With social programs being cut in the communities, young people are going to have a lot more free time on their hands and this program will give them a place to go and something to do that will keep them out of trouble.

If you look at those reasons, you will see that this program is aimed at the total person, not just athletic or anything like that. It develops the total person. Probably the biggest point that I'd like to leave with you today is that I hate to see our future youth deprived of something myself, my family, and many, many others have benefited from so greatly.

Senator RUDMAN. Thank you very much, Mr. Griffin. We do appreciate your taking the time. You certainly are an incredible example of what the program can do and we appreciate it.

Mr. GIESE. Do you have any other questions?

Senator RUDMAN. Do you have any other members of the panel who wish to address us this morning?

Mr. GIESE. We would be happy to answer any questions that you have. At this time we have no other direct testimony.

Senator RUDMAN. I just want to be absolutely sure. I think what your written statement contains and what you have said here is that it is your belief that if there is not continued Federal funding, then private funding, NCAA funding, and other source funding, probably will not be forthcoming because of various budgetary difficulties.

Mr. GIESE. With the size of the budget at $6 million, Senator Rudman, and if you were to sell all the assets of the NCAA, for instance, you could operate 1 year. So it must come from other sources. We don't believe it can remain as it has these last years without Federal assistance.

Senator RUDMAN. Do you have any questions?

Senator BURDICK. No questions.

Senator RUDMAN. Again, thank you very much for coming here and giving us your testimony. It will be given, I can assure you, very serious consideration.

[The statement follows:]

STATEMENT OF DR. WARREN K. GIESE

Mr. Chairman and members of the Subcommittee, I am Dr. Warren K. Giese, a professor at the University of South Carolina and Chairman of the National Youth Sports Program National Advisory Committee. Also with me here today to speak in favor of appropriations for the NYSP is Archie Griffin, tailback for the NFL Cincinnati Bengals, businessman, twice winner of the Heisman Trophy, three-time All-American, and a former participant and instructor in the NYSP at Ohio State University.

We are also accompanied by Dr. William Bradley, Chief Evaluator of the NYSP, and Professor of Physical Education at Western Illinois University; Mr. James H. Wilkinson, Assistant Executive Director of the National Collegiate Athletic Association and National Program Director of the NYSP; Mr. Ronald A. Bond, Director of Recreation at the University of Pennsylvania and a local NYSP Project Administrator; and Mr. Gregory Stephens, a young man from West Philadelphia who was an NYSP participant, and who is now a senior, first-year dental student, NYSP program aide and member of the varsity track team at the University of Pennsylvania. These gentlemen are all available to answer any questions you may have.

I am making this statement in support of appropriations for the National Youth Sports Program. With your permission, I would like to have inserted in the record a fact sheet which describes some of the accomplishments of this program.

The National Youth Sports Program annually provides about 50,000 of our nation's disadvantaged youth, ages 10-18, a year-round opportunity to benefit from high quality athletic and other educational resources made available by colleges and universities throughout the country. I particularly want to emphasize that a minimum of 90 percent of the NYSP's participants meet the poverty income guidelines established by the

Community Services Administration. Thus, this is a program which directly serves those who are truly in need.

The program is a joint undertaking of the Federal Government, the National Collegiate Athletic Association, and 135 colleges and universities. In 1980, with a $6 million grant from the Community Services Administration and over $11.5 million in contributions from other sources, the NYSP carried out its twelfth successful year.

The typical NYSP project serves about 300 youngsters, nearly evenly divided between boys and girls. College and high school coaches and outstanding athletes provide instruction in at least four sports. The ratio of participants to staff averages about 16 to 1. In this way, participants receive the benefit of personal contact with people who can serve as valuable role models.

An extremely important part of each project is the enrichment component. Each project provides instruction in drug and alcohol abuse prevention, health and nutrition, and career and educational opportunities. The NYSP also draws upon the outstanding educational and cultural resources available on and near the campuses of participating institutions.

Each participant benefits from a free medical examination and, if necessary, follow-up. The NYSP also provides free medical and dental insurance for each participant. And each participant daily receives at least one free, nutritionally balanced meal, which meets U.S.D.A. standards. As you can see, the focus is not sports alone; the NYSP aims through the motivating power of sports to promote the development of the whole person.

In this way, the NYSP serves as a bridge between needy youngsters living in many of the poorest neighborhoods in our nation and the stable, positive environment of nearby colleges and universities. This important role in promoting good community relations, part of the program's design philosophy, helps to direct the energies of young people from poor neighborhoods into constructive channels, and to turn such youngsters away from destructive behavior patterns. As the availability of funding for other programs aimed at problems of the poor is reduced, there will be an increasing need for constructive programs of this kind.

In real dollars, the NYSP appropriation has been reduced consistently in each year since 1975, the last year in which its appropriation was increased. I would also like to point out, that in the effort to contain Federal spending, the NYSP now is not merely being asked to cut back in proportion to overall spending reductions -- this program is threatened with termination.

In our view, there are significant reasons for a continuing Federal role in funding this program. First, is the ability of the program to apply Federal dollars directly to its purposes with a minimum of intervening administrative structures or expense. Administration of the program through the NCAA is highly cost effective.

Second, and connected closely with the first point, is the ability of the program to use Federal money to generate private contributions. Consistently, more than one dollar in private contributions matches each Federal dollar. This program serves as a magnet for attracting the kind of voluntary efforts most of us favor.

The NYSP is not a hit or miss program. It receives careful annual evaluation, under the direction of Dr. Bradley. The National Youth Sports Program knows what it is doing. All NYSP projects are examined by experienced evaluators who publish reports of on-site visitations. These evaluators measure each program against stated NYSP objectives. The evaluation process is constantly being refined.

Finally, I want to emphasize a point of most immediate concern. The appropriation for this summer's NYSP, under the continuing resolution enacted by Congress, has been deferred by the Administration until June 30, 1981. Unless this deferral is ended, or 1981 funds are otherwise appropriated for the program, the NCAA will not be able to operate the NYSP this summer. Therefore, we come before you to ask that this 1981 funding crisis be resolved, in addition to seeking an appropriation for FY 1982. Without Federal support, the NYSP as it now exists will not survive.

STATEMENT OF FRANCISCO CASTELLANOS, NATIONAL REPRESENTATIVE, NATIONAL ASSOCIATION OF FARMWORKER ORGANIZATIONS

ACCOMPANIED BY:

SUSAN HOECHSTETTER STAFF MEMBER, NAFO
SANDY HARDING, STAFF MEMBER, NAFO

Senator RUDMAN. Mr. Castellanos, of the National Association of Farmworker Organizations.

Mr. CASTELLANOS. Thank you very much, Mr. Chairman.

Mr. Chairman and members of the Senate Labor-HHS-Education Subcommittee on Appropriations, I am Francisco Castellanos, national representative with the National Association of Farmworker Organizations. Accompanying me today are Susan Hoechstetter and Sandy Harding, staff members of the organization. On behalf of the farmworker-governed organizations and individuals which comprise NAFO's membership, I wish to thank this subcommittee for requesting the testimony which will be presented today.

Incorporated in 1973, NAFO is a national coalition dedicated to the protection of civil and labor rights of migrant and seasonal farmworkers and to the development of activities and programs for the benefit of the Nation's farmworkers. Our comments today will not vary significantly from testimony presented to the 93d Congress through that of the present, nor from recommendations made to both Republican and Democratic administrations from the Nixon administration through today's administration of President Ronald Reagan.

Farmworker families have long been one of the Nation's truly needy populations. Despite their contributions to the economic well-being of agricultural communities, States and the Nation as a whole, national statistics continue to show that infant mortality among migrant farmworkers is 24 percent higher than the national average; incidence of infectious disease is evidenced as 20 percent higher among migrants than among other groups in our society; migrant births outside of hospitals occur at a rate nine times higher than the national average; and incidence of malnutrition is higher among migrants than any other subpopulation in the country.

The USDA Economic Research Service's, the Hired Farmworking Force Survey of 1979, reveals that the average earnings for a period of 250 days and over within agricultural labor during 1979 were $2,489. Such earnings all too pointedly reveal needs which will occur in relation to farmworker health, education, housing, nutrition, energy, employment and training, et cetera. Average farm labor earnings, coupled with the escalating rate of inflation for primary goods, will simply not enable the farmworker to provide for his or her family's needs.

Despite the preponderance of need within the population, farmworker families do not generally participate within the major public assistance programs offered through the Federal Government, with the exception of limited participation within the food stamp program. In fact, the farmworker data network of the Colorado Migrant Council reports that 89 percent of the farmworker respondents which were represented within their national data base do not receive any form of public assistance.

A few Federal programs do exist, however, which were designed to address the unique needs of migrant and seasonal farmworkers, two of which are funded through national set-asides within the community food and nutrition program and the energy crisis intervention program, both administered through title II, part B, section 222(a)(5) of the Economic Opportunity Act. Administered nationally, the programs reach the community through the service delivery of farmworker-governed, community-based organizations and regional coalitions or conduits of the farmworker organizations. National administration of the programs provides the vehicle for interstate response to the needs of the population.

Let me try to summarize as best I can. I know that the time is running short. Perhaps HEW's 1979 "Migrant and Season Farmworkers: A Service Delivery Assessment" best sums up the value of such programs. A major finding of the report was that general HEW programs did not reach migrant farmworkers, nor did a service delivery system exist as such for farmworkers. On the other hand, HEW identified the migrant health program as the single HEW health program serving all types of farmworkers and their dependents; migrant education as highly visible to farmworker families with dollars going to services rather than for administrative or management function; and migrant day care programs as serving the population by removing infants and children from the fields.

We feel that we view the continued funding support of existing Federal farmworker programs to be critical—both with respect to programs authorized within the Economic Opportunity Act and those programs authorized through other legislation. We continue to be concerned, however, that no mechanism exists within our Federal system to coordinate policy, planning and service delivery of the programs.

The Reagan administration's fiscal year 1982 budget proposal further fragments the system by proposing that CFNP, ECIP and the migrant health program be administered through a health and human service block grant to the States—an administrative vehicle which is unworkable for a population whose needs are very clearly interstate. At the same time, migrant education would be combined with varied education programs in block grants to local education agencies, while some Federal programs for farmworkers would remain as is.

If enacted, the Reagan administration's budget proposal would accomplish a major reorganization within the Federal Government, implementing a systems change through the funding process. As such, decisions regarding the funding levels of Government programs should not be made without due attention devoted by Congress to the systems which administer the funds—systems which can themselves be improved to administer the services they were mandated to perform in a more efficient and effective manner.

The advocates of programs for migrant and seasonal farmworkers have long articulated the need for a national policy regarding farmworker needs and the role of farm labor in the national economy. There are certain things that we think should be done: Resolve the current problems of fragmentation and lack of uniformity which result in the administration of farmworker programs through various agencies within the Federal Government; the promotion of administrative cost efficiency and effectiveness through a single point of coordination within the Federal system; and maintain the national administrative vehicle which is so critical to serving a population which transcends static State and regional boundaries.

Despite any current problems of administration, the farmworker programs authorized through the Economic Opportunity Act hold the same importance and need within the community as when they were first enacted into law. In fact, a strong case can be made that the programs are even more viable today as farmworker families are faced with inflationary demands within the costs of food, gasoline, home fuel, et cetera, and as food production becomes an increasingly important tool within our country's economy and international relations.

In conclusion, I'd like to summarize by saying that we are raising the issue of national coordination among all these different programs and efforts to assist migrants and farmworkers and one particular high priority is the concept of Federal programs coordination has never been implemented. We have had different programs available for migrants and farmworkers. The evidence is that the scope of need is such that even with the full implementation of these programs as efficiently as possible, we are only serving approximately 8 to 10 percent of the need in this area and the need in this area is very dramatically documented already, historically documented already.

We raise the concept that is highlighted in title IV of the Economic Opportunity Act. This title contains the only legislative authority existent to coordinate and monitor the Federal farmworker programs. In raising this concept of title IV, we feel this is one which is still viable and can serve as the focal point in beginning the process of developing the most effective, cost efficient means of providing service to migrant and seasonal farmworkers.

We are not suggesting through this statement that title IV of the Economic Opportunity Act be used to coordinate all Federal farmworker programs through the Community Services Administration, particularly since the language has not been fully implemented since the dismantlement of the Office of Economic Opportunity and since CSA's continued role within the Government is being questioned. We are willing to emphasize, however, the fact that this need for Federal coordination of services to this particular segment of the population is particularly needed and now that this administration is proposing a major change in services to this particular population as to how it is to be provided we think Congress should take this opportunity as a golden opportunity to look at the best, most effective, and most efficient way to coordinate the few services that are being provided serving this population. We thank you for your time.

[The statement follows:]

Statement of Francisco Castellanos

I am Francisco Castellanos, National Representative with the National Association of Farmworker Organizations (NAFO). Accompanying me today are Susan Hoechstetter and Sandy Harding, staff members with NAFO. On behalf of the farmworker-governed organizations and individuals which comprise NAFO's membership, I wish to thank this Subcommittee for requesting the testimony which will be presented today.

Incorporated in 1973, NAFO is a national coalition dedicated to the protection of civil and labor rights of migrant and seasonal farmworkers and to the development of activities and programs for the benefit of the nation's farmworkers. Our comments today will not vary significantly from testimony presented to the 93rd Congress through that of the present, nor from recommendations made to both Republican and Democratic Administrations from the Nixon Administration through today's Administration of President Ronald Reagan.

Farmworker families have long been one of the nation's "truly needy" populations. Despite their contributions to the economic well-being of agricultural communities, states and the nation as a whole, national statistics continue to show that:

- infant mortality among migrant farmworkers is 24% higher than the national average;
- incidence of infectious disease is evidenced as 20% higher among migrants than among other groups in our society;
- migrant births outside of hospitals occur at a rate nine times higher than the national average; and
- incidence of malnutrition is higher among migrants than any other subpopulation in the country.

The USDA Economic Research Service's "The Hired Farmworking Force Survey of 1979" reveals that the average earnings for a period of 250 days and over within agricultural labor during 1979 were $2,489. Such earnings all too pointedly reveal needs which will occur in relation to farmworker health, education, housing, nutrition, energy, employment and training, etc. Average farm labor earnings, coupled with the escalating rate of inflation for primary goods, will simply not enable the farmworker to provide for his/her family's needs.

Despite the preponderance of need within the population, farmworker families do not generally participate within the major public assistance programs offered through the federal government, with the exception of limited participation within the Food Stamp Program. In fact, the Farmworker Data Network of the Colorado Migrant Council reports that 89% of the farmworker respondents which were represented within their national data base do not receive any form of public assistance.

A few federal programs do exist, however, which were designed to address the unique needs of migrant and seasonal farmworkers, two of which are funded through national set-asides within the Community Food and Nutrition Program and the Energy Crisis Intervention Program (both administered through Title II, Part B, Section 222(a)(5) of the Economic Opportunity Act). Administered nationally, the programs reach the community through the service delivery of farmworker-governed, community-based organizations and regional coalitions or "conduits" of the farmworker organizations. National administration of the programs provides the vehicle for interstate response to the needs of the population.

Other federal programs which exist to serve the unique needs of migrant and seasonal farmworkers are the Migrant Health Program (HHS), Migrant Education (ED), Migrant Head Start (HHS), Farm Labor Housing (USDA) and the Farmworker Employment and Training Program (DOL). Perhaps HEW's 1979 "Migrant and Seasonal Farmworkers: A Service Delivery Assessment" best sums up the value of such programs. A major finding of the report was that general HEW programs did not reach migrant farmworkers, nor did a service delivery system exist as such for farmworkers. On the other hand, HEW identified the Migrant Health Program as the single HEW health program serving all types of farmworkers and their dependents; Migrant Education as highly visible to farmworker families with dollars going to services rather than for administrative or management functions; and Migrant Day Care Programs as serving the population by removing infants and children from the fields.

NAFO views the continued funding support of existing federal farmworker programs to be critical -- both with respect to programs authorized within the Economic Opportunity Act (CFNP and ECIP) and those programs authorized through other legislation. We continue to be concerned, however, that no mechanism exists within our federal system to coordinate policy, planning and service delivery of the programs.

The Reagan Administration's FY 1982 Budget Proposal further fragments the system by proposing that CFNP, ECIP and the Migrant Health Program be administered through a health & human service block grant to the states -- an administrative vehicle which is unworkable for a population whose needs are interstate. At the same time, Migrant Education (title I, ESEA) would be combined with varied education programs in block grants to Local Education Agencies (LEAs), while some federal programs for farmworkers would remain as is.

If enacted, the Reagan Administration's Budget Proposal would accomplish a major reorganization within the federal government -- implementing a systems change through the funding process. As such, decisions regarding the funding levels of government programs should not be made without due attention devoted by Congress to the systems which administer the funds -- systems which can themselves be improved to administer the services they were mandated to perform in a more efficient and effective manner.

The advocates of programs for migrant and seasonal farmworkers have long articulated the need for a national policy regarding farmworker needs and the role of farm labor in the national economy, as well as the need for a national coordination of available resources to the farmworker population which would:

- resolve the current problems of fragmentation and lack of uniformity which result from the administration of farmworker programs through various agencies within the federal government;
- promote administrative cost efficiency and effectiveness through a single point of coordination within the federal system; and
- maintain the national administrative vehicle which is so critical to serving a population which transcends static state and regional boundaries.

Despite any current problems of administration, the farmworker programs authorized through the Economic Opportunity Act hold the same importance and need within the community as when they were first enacted into law. In fact, a strong case can be made that the programs are even more viable today as farmworker families are faced with inflationary demands within the costs of food, gasoline, home fuel, etc. and as food production becomes an increasingly important tool within our country's economy and international relations.

In addition to the continued importance of the self-sufficiency and emergency assistance provisions within the Community Food and Nutrition Program and the Energy Crisis Intervention Program, the Economic Opportunity Act contains within title IV the very foundation for the federal government's response to migrant and seasonal farmworkers. Title IV also contains a legislative concept of primary significance to current proposals regarding administrative restructuring and efficiency. Title IV, EOA, contains the only legislative authority existant to coordinate and monitor the federal farmworker programs. Previously within title III-B of the Economic Opportunity Act, the section was elevated to the separate title IV by Congress in 1978 to direct attention to the needs of migrant and seasonal farmworkers and their families.

We are not suggesting through this statement that title IV of the Economic Opportunity Act be used to coordinate all federal farmworker programs through the Community Services Administration, particularly since the language has not been fully implemented since the dismantlement of the Office of Economic Opportunity and since CSA's continued role within the government is being questioned. We are, however, raising the concept within title IV of EOA as one which is still viable and can serve as the focal point in beginning the process of developing the most effective and cost efficient means of providing services to migrant and seasonal farmworkers.

The very characteristics which identify families as migrant or seasonal farmworkers -- occupation, income, mobility within and across geographic boundaries, culture and education -- are the same characteristics which necessitate the development of specialized programs and systems of delivery to address the needs of this "truly needy" population. Current programs for farmworkers within the Economic Opportunity Act serve a definite need within farmworker communities and deserve to be funded at a level no less than last year's appropriation amounts. As important is the administrative vehicle through which the funds are administered and services are delivered.

Community-based farmworker organizations have traditionally been points of multi-service coordination within the communities, bringing together segmented programs from a number of agencies into integrated, comprehensive programs for farmworkers. Current national proposals of creating reorganization within the federal government through the funding process allow a prime opportunity for discussion of the same as it affects migrant and seasonal farmworkers, utilizing the existing strengths and networks created by the community-based farmworker organizations throughout the past 15-20 years.

Thank you.

CONCLUSION OF PANEL

Senator RUDMAN. Senator Burdick, any questions?

Senator BURDICK. No questions.

Senator RUDMAN. Thank you very much.

We will now conclude with the panel on the Corporation for Public Broadcasting; Frank Norwood, executive director of the Joint Council on Educational Telecommunications; and the other panelist is David Carley, president of the National Association of Public Television Stations. In addition, accompanying Mr. Carley is Dennis Falk, station manager of the public TV and radio stations in North Dakota, and I believe Senator Burdick would like to make a comment for the record and I invite you to do so at this time.

Senator BURDICK. Mr. Chairman, it's indeed a pleasure for me to welcome one of North Dakota's outstanding citizens, Dennis Falk, of KFME Public Television, Fargo, N. Dak. Mr. Falk is an outstanding manager, has been the architect of the public broadcasting system in North Dakota, has worked closely with the State legislature and communities and the North Dakota congressional delegation, to be able to secure funding for public broadcasting in North Dakota.

Most important, he has succeeded in firmly establishing a quality public broadcasting service in North Dakota and, again, it's my pleasure to welcome him to the committee.

Mr. FALK. Thank you, Senator.

Senator RUDMAN. Thank you, Senator.

Mr. Norwood.

STATEMENT OF FRANK W. NORWOOD, EXECUTIVE DIRECTOR, JOINT COUNCIL ON EDUCATIONAL TELECOMMUNICATIONS

Mr. NORWOOD. Thank you, Senator. I appreciate the opportunity to be here and testify this morning.

Senator RUDMAN. Let me just ask you a question just for our record here. I believe that I've named three people and I see five people here. Can you introduce yourselves?

Mr. NORWOOD. I'm Frank Norwood, and I'll let the others introduce themselves.

Mr. LARSON. I'm Robert Larson, general manager of Station WITF in Hershey, Pa.

Mr. FALK. I'm Dennis Falk, general manager of KFME, Fargo, N. Dak.

Mr. CARLEY. David Carley, president of the National Association of Public Television Stations.

Mr. CHAMBERLIN. Ward Chamberlin, president and general manager of WETA, the local Washington, D.C. area public television station.

Senator RUDMAN. Gentlemen, thank you very much.

Mr. NORWOOD. I'm Frank Norwood, executive director of the Joint Council on Educational Telecommunications.

The organization was formed 30 years ago and was called then the Joint Committee on Educational Television, and its specific purpose in the formation of it was to bring together the major educational organizations of the United States—the American Council on Education, the Association of Land-Grant Colleges, the Council of Chief State School

Officers, and the National Education Association, and several others—in order to persuade the Congress and Federal Communications Commission that television channels should be set aside for noncommercial broadcasting.

If that activity hadn't taken place then and if that fight hadn't been successful, we would hardly now be considering the matter of public television. So our interest and our stake in this effort go back as long a time as any.

I'm here to speak about the proposed "rescission" and I use that in quotation marks because it seems to me it is not as the other rescissions are, and the funds for fiscal years 1982 and 1983. It seems to me it is not a question of whether public broadcasting should escape the belt-tightening that's going on in every aspect of our society, and the question has nothing to do with whether CPB's administrative costs are excessive or whether its efforts on program funding have been valuable or not. The question is not whether stations should receive a smaller or larger share of the the Federal dollars.

The question is whether public broadcasting can maintain its independence. The question is whether public radio and television is to be converted in this country into State broadcasting systems.

Congress, with what I believe was great wisdom, established the principle in the Public Broadcasting Financing Act of 1975 of forward funding and that principle is reiterated in the Public Telecommunications Financing Act.

The funds for 1982 and 1983 have already been appropriated and have been deposited with the Secretary of the Treasury in the public telecommunications fund. Now if this Congress and this administration can set aside an action that was taken by a previous Congress and a previous administration for fiscal reasons, then future Congresses and administrations will be able to interfere with the funding of public broadcasting for reasons of programing or politics.

I think the freedom of public broadcasting is at risk. I find it chilling that the Office of Management and Budget in America's "New Beginning" proposes to cut funds which are already appropriated and then to direct public broadcasting how the cut should be made.

"The reductions will be primarily directed at CPB," they say in "New Beginning," "administrative cost and national program production, while CPB support for local stations will be maintained at as high a level as possible."

The Congress, in the Public Telecommunications Financing Act of 1978, provided instructions to the Corporation on how its funds should be spent. That's entirely appropriate. I don't quibble with the idea that the Congress can instruct the Corporation. But the way that's done, if the Corporation requires further instruction, Congress will have an opportunity when it considers reauthorization legislation. It's quite another matter for the OMB to dictate to the Corporation, which is not an arm of the Federal Government, or to any part of public broadcasting.

So I say, borrowing a famous statement of Voltaire and modifying it to fit the present circumstances, "that even the Corporation's most bitter enemy would have to say in this case I agree with what you say, but I would oppose with my life your right to say it."

Senator RUDMAN. Thank you, Mr. Norwood.

[The statement follows:]

STATEMENT OF FRANK W. NORWOOD

I am Frank W. Norwood, Executive Director of the Joint Council on Educational Telecommunications. The JCET was founded more than thirty years ago by some of the most distinguished educational organizations in the nation including, the American Council on Education, the Association of Land-Grant Colleges, the Council of Chief State School Officers and the National Education Association. It was then known as the Joint Committee on Educational Television, and the specific purpose for which it was organized was to persuade the Federal Communications Commission and the Congress that wise public policy required that channels, in the then-new business of television broadcasting, be reserved for educational and noncommercial purposes.

In 1952 the JCET efforts were rewarded when the Federal Communication Commission in its Sixth Report Order set aside 242 channels for noncommercial educational television. If those reservations had not been made, the opportunity for what is now known as "public television" would have been lost forever and the Congress would not be now considering what to do about appropriations for the Corporation for Public Broadcasting.

The proposed "recission" of the CPB appropriation is, I believe, a matter of gravest concern.

The question is not whether public broadcasting should be spared from the belt-tightening which every
sector of our society faces.

The question has nothing to do with whether CPB administrative costs are excessive, or whether its efforts in program funding have been of value.

The question is not whether the stations should receive a greater or smaller share of federal dollars.

The question is whether public radio and television can maintain its independence. The question is whether public radio and television is to be converted into a system of state broadcasting.

Congress, with what I believe was great wisdom, established the principle of forward funding for public broadcasting in the 1975 Public Broadcasting Financing Act and retained the important principle in the 1978 Act under which the Corporation funding was authorized through FY 1983. The funds for FY 1982 and FY 1983 have already been appropriated and have been deposited with the Secretary of Treasury in the Public Telecommunications Fund. If this Administration, and this Congress can, for fiscal purposes, take back what has already been appropriated by another administration and another Congress, then future Congresses will be able to "rescind" appropriated funds for reasons of programming or politics.

The freedom of Public Broadcasting in the United States is at risk.

I find it chilling that the Office of Management and Budget, in America's New Beginning, proposes to cut funds which have already been appropriated and to direct the public broadcasting community as to how those cuts should be made.

"The reductions will be primarily directed at CPB administrative cost and national program production, while CPB support for local stations will be maintained at as high a level as possible."

The Congress, in the Public Telecommunications Financing Act of 1978, provided instructions to the Corporation on how its funds should be spent. That is entirely appropriate. And if the Corporation requires further instruction, Congress will have opportunity to provide it in reauthorization legislation.

It is quite another matter for the Office of Management and Budget to dictate to the Corporation, which is not an arm of the Federal government, or to any part of public broadcasting.

Under the circumstances, the Corporation's most bitter critic would have to say, "I agree with what you say, but I would oppose with my life your right to say it."

STATEMENT OF DAVID CARLEY, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC TELEVISION STATIONS

Senator RUDMAN. Mr. Carley.

Mr. CARLEY. Mr. Chairman, Senator Burdick, as I said a moment ago, my name is David Carley, president of the National Association of Public Television Stations. We have a statement that we would like to have inserted in the record. I think it's a complete statement in terms of what we want to say and we appreciate the opportunity for additional comment.

I and my colleagues who you asked to be introduced represent not only the District of Columbia—Washington, D.C.—but also a good part of the States of Pennsylvania and North Dakota.

Last week this committee heard from Dr. Robben Fleming, president of the Corporation for Public Broadcasting. Dr. Fleming in addressing this committee talked about the prospects of the cuts proposed under the rescission, and what they would mean at a national level. Our effort today will be quite a bit different, and that is to discuss what that really means for public television in America, and what it means for 171 licensees of 273 public television stations in America.

Our great concern, in addition to the arguments that Mr. Norwood made on rescission, is that we want to say additionally that the matter of rescission is of profound concern to us, not only as those of us who are concerned and work within the community of public broadcasting, both radio and television, although today representing television; but we are concerned about the matter of insulation from political caprice or at the very worst political intimidation.

The matter of planning for public television stations of the programs seen at the national level is vital. "Sesame Street," "Nova" and "McNeil-Lehrer" programs, of course, take more than 6 or 12 months to prepare. Some of the finest programs—all the way from the Mississippi public stations on Faulkner to the Nebraska programs—have come up this year. We have our highest television ratings in the history of public television. It's somewhat ironic that in Congress, at the very time the Senate and the House and the national administration would be considering cuts, that two-thirds of all American families monthly watch at one time or another public television. One-half watch it weekly throughout all of America. The best ratings in the history of public television have been in the past winter for the program schedules that most Americans have seen.

The impact of rescission will be on local programing. As much as the national officials that you heard from last week are concerned from an overall view, the real impact will be on local programing in America. The quality of local programing and the diversity of America's culture, of political institutions, of educational institutions, instruction and education will be seriously affected by a 25-percent cut. May I also say that it isn't just 25 percent in the national CPB budget, but some $25 million also in public television has come from, in the last year, the National Endowment for Humanities and the National Endowment for the Arts. So we are suffering not only a 25-percent cut of local programing, but much more like a 50-percent cut in terms of the total funds received from the Federal Government, and this is the context, ladies and gentlemen, that we really ought to be thinking about.

Additionally, I'm not at all sure that all of the Congressmen and Congresswomen that I talk to fully understand that the fixed costs of interconnection—the satellite system formerly the terrestrial system and now the satellite system—are paid for, and for the music copyrights also, by the local PTV stations. In action just yesterday, the National Corporation of Public Broadcasting decided that all of the music copyright fees are to be paid for by the local stations.

Frankly, it's my belief and view that in the past Congress had intended that the interconnection system and that music copyright fees would be paid for at the national level. The Corporation Board yesterday in its meeting, and will conclusively establish, it seems, in April and May that these fees will be paid for by these gentlemen here today and the 168 other local television licensees.

The demographics of public television are important. It's been said by some columnists—Mr. Safire, Mr. Buchanan and others who seek to see the end of any public funding for public broadcasting and radio and particularly television—that PTV viewers don't represent America any more. I'd like this committee to know and be on record, that the demographics of America—I talked in quantitative terms a moment ago about how many see it—all of America demographically—age, race, income classes, and sex—view public television exactly proportionate to what those percentages are in the American society. We aren't off even 1 percent. So it would be totally incorrect to say that public television is an elitist operation in America.

We can point to figures that many, many minority children receive their finest instruction from educational programs in public television.

I believe my colleagues have additional comments to make and thank you very much for your attention.

[The statement follows:]

STATEMENT OF DAVID CARLEY

Mr. Chairman and members of the Committee: On behalf of the National Association of Public Television Stations, I am grateful for the opportunity to appear before you today to express our views on the 1982 and 1983 appropriations to the Corporation for Public Broadcasting and the regular FY1984 CPB request.

Introduction

The Administration has asked Congress to rescind 25 percent of the Corporation's 1982 funds and some 30 percent of its funds for 1983. Local public television licensees and their lay supporters are united in asking Congress not to rescind the dollars appropriated to CPB in previous years. We also seek adequate federal support in FY1984.

We recognize fully the need to restrain federal spending. However, to turn back funds already appropriated to CPB would be to violate an important principle-- that public broadcasting must be insulated from political and financial pressure by Congress or the Executive Branch. The unique advance appropriation for public broadcasting is essential to maintaining this principle. It protects the people who watch and listen to public television and radio from improper federal government influence on the programs they enjoy. It also provides stable, predictable income to public broadcasters, enabling them to serve their communities more effectively. Without the advance appropriation, public broadcasters are not secure against political pressure, nor can they make the long-term commitments necessary to create programming of excellence.

We have no reason to believe that the Administration in any way intended to undermine the insulation principle and its benefits to the public. However, were the Congress to rescind even a portion of funds already appropriated to the CPB, the principle would be lost and the door opened for political instrusion in the future. The advance appropriation mechanism was crafted carefully by public broadcasters and the federal government; it was wise when instituted, and remains wise and proper today.

Beyond the principle, which we feel must be preserved, we have other concerns. Even if CPB's appropriation remains untouched, public television and radio will be absorbing their "fair share" of budget cuts in fiscal 1981 and 1982. For example, during fiscal year 1980 public television and radio received $23.7 million in facilities grants for extending service to unserved areas--mostly in the West--and replacing vital capital equipment. The Administration has asked Congress to eliminate this program. Last year, public television and radio received about $35 million in program assistance from the Department of Education, the National Endowments for the Arts and Humanities, and the National Science Foundation, among others. We estimate that over $20 million of these funds would be eliminated by the Administration's proposed cuts. If this happened, other sources of support would be asked to bear a significantly larger portion of the cost of such public television series as SESAME STREET, NOVA, 3-2-1 CONTACT, and GREAT PERFORMANCES series. Many local and regional program supported by the endowments would have to seek other funds. Frankly, we do not believe the money is there to replace these federal dollars.

The loss of education department funds now going to universities and school districts could generate many more millions in local budget cuts for their public television stations. These reductions would translate into real service cuts for disadvantaged people--for example, Americans in Alaska and Appalachia who use Department of Education-funded TV home learning programs to upgrade their basic reading and writing skills. For these people, we are not talking about a lost TV program, but a lost opportunity. Finally, public broadcasting is lean enough already. Many stations have been losing ground to inflation in recent years. Last year, Boston's WGBH was forced to lay off one-quarter of its staff. Other stations report similar lay-offs or declining state and local funding--their budgets are pinched now and will be tighter next year, regardless of what happens to CPB.

Consequently, we suggest to you that the CPB budget ought to be considered within the traditional procedure--in other words, that CPB's FY1984 spending request (part of the 1982 budget) should be scrutinized just as carefully as all other budgets will be. However, the need for continued insulation, coupled with other cuts in public television's federal support argue against the abrupt recision of CPB funds for FY1982 and 1983.

Public Television Today

Today, there are 292 public television stations, licensed to 171 non-profit community organizations, colleges and universities, state agencies, and local school systems. Each of these diverse local units has developed, in close consultation with its community, a unique mix of services. Some stations emphasize educational and instructional programs for children and adults, others local public affairs or cultural series. Often, minority groups and particular communities of interest are singled out for special local attention. Stations have also found it efficient to pool some of their limited resources to purchase regional or national programs on a cooperative basis. Thus, each station offers a mixture of local, regional and national programs, determined locally, in response to the needs and interests of its community.

Diverse as they are, the nation's local public television stations share a tremendous record of success, as indicated by the public's enthusiastic endorsement of the job they are doing. For example, since 1975, the number of families donating funds to their local station has doubled, to more than two and one half million. In part, this increase can be attributed to the stimulus provided by federal matching funds. But it is also true that more people now watch and appreciate public television than ever before. Monthly viewing has grown from 34 million families in March 1975 to 52 million in March 1980--a 54 percent increase in just five years. This growth continued throughout 1980, reaching a milestone in early December 1980, when for the first time ever, over half of the nation tuned in to public television during a single week. And, as public television has grown, so has instructional TV, which in 1978-79 reached an estimated 14 million school children every day, using broadcast and video-cassette delivery.

We are also pleased with who is watching public television, not just how many. Now, more than ever before, the make-up of public television audience closely reflects the demographics of the U.S. population as a whole. During the March 1980 audience survey period, over fifty percent of the families headed by people earning less than $10,000 per year watched public television, as did more than half of those in homes headed by a person lacking a high-school diploma. There is no better evidence of public television's broad appeal than its attraction of substantial numbers of viewers from all income and education levels.

Public television's success is fueled by a mixture of funding from all levels of government, businesses, family contributions, foundations, and colleges and universities. The federal government's role is relatively modest--contributing about one quarter of public television's annual income. Federal dollars support several "national" activities--program grants, satellite interconnection costs, music copyright royalty payments and the like. But a substantial portion (some 60 percent of the CPB appropriation) passes directly to television and radio stations in the form of unrestricted Community Service Grants (CSGs). At the local level, these grants play a crucial role--for two reasons. First, the CSG comes to the stations with virtually no "strings" attached. For that reason, many stations rely on the CSG as their only sizeable, predictable source of discretionary income. With most local dollars earmarked for relatively fixed operating costs or specific projects, the CSG allows stations to undertake new activities the private sector and local institutions may not be able to support. For example, in Medford, Oregon, the local station (KSYS) uses its entire CSG to buy programs through the Station Program Cooperative (SPC) and to purchase instructional programs for the local school system. Were the CSG to be cut, KSYS would have to reduce its SPC purchases, or eliminate its school service outright. I might add that KSYS, a community licensee, receives no state funding--unlike the other Oregon stations--and depends wholly on voluntary community support and the CSG for its livelihood.

An additional virtue of the CSG is that it is nearly all net income, demanding very little in the way of "fund-raising" expenses. This makes it even more valuable than its portion of the typical station budget--15 percent--would suggest.

Effects of A Recision

The recision proposed would have one of two effects, depending upon how the Corporation acted upon it. In one scenario, CPB could simply reduce its expenditures across the board, with each segment sharing in a 25 percent reduction. (Some of CPB's costs are inflexible--the annual music copyright payment and satellite interconnection payments total about $11 million annually and cannot be reduced.) With fixed costs exempted from the cuts, television CSGs would have to be reduced by 25 percent or more, as would national programming. Given the importance of the CSG to local service, such a reduction would injure local stations severely, particularly smaller stations that depend more heavily upon the CSG. The stations' reduced purchasing power would force many to cancel contracts for programs already purchased through the Station Program Cooperative, now in its final bidding stages. With most stations' 1982 fiscal years beginning on July 1, 1981, stations might also have to cancel local programs, since there would be no time to secure other funds to sustain them.

OMB has suggested an alternative path--holding the dollar level of station grants constant, and absorbing cuts in the CPB budget by reducing only CPB's programming and administrative costs. Although stations generally believe that greater local control over national programs would yield better service to their communities, simply eliminating national programming funds is not the way to achieve that purpose. With national program funds reduced, stations would have to absorb extra program costs at the local level, thus placing a new burden on scarce local funds. The result would be a large net loss. We also believe that directives to CPB concerning the appropriate balance of CPB expenditures should continue to be provided by the authorizing legislation for the system.

We also stress that public television stations, who are already working flat out to raise private funds, would be unable to "make up" more than a small percentage of the loss of federal funding by generating more private support. Individual memberships and business contributions account for only about 21 percent of public television's annual income. Even if the current rules governing private fundraising were relaxed in some way, the system could not raise enough dollars to adjust to the loss of $88 in net income from CPB, the education department, the science foundation, and the endowments. In fact, it could be argued that the federal cuts will actually reduce private giving, since many federal grants are used to stimulate matching funds locally.

In summary, we must oppose any recision of CPB's 1982 and 1983 appropriations. The insulation principle, supported by the advance appropriation, must be protected. In addition, public television's "fair share" of cuts already appear to be taking shape, as reductions loom at other agencies supporting public television. Now is not the time to make further abrupt cuts that will deny the American people a healthy public broadcasting system, independent from political intrusion in its programming.

Appropriations for 1984

Our views regarding fiscal 1984 funds for public broadcasting are somewhat premature, since 1984 dollars have yet to be authorized. In general, we believe that the federal matching provision, which authorizes fifty cents for each non-federal dollar raised, should be allowed to work. With non-federal support projected to reach $586 million in FY1982 (the match year for FY1984), this would mean a 1984 appropriation of $293 million. These funds could be used to:

1. Complete public radio and television coverage of the nation, extending to the citizens of the Western states and other unserved areas the public broadcasting services they deserve.

2. Increase grants to existing stations, for use in meeting local priorities.

3. Expand national and regional programming, in order to meet the public's need for universally-available cultural, public affairs, and educational services.

4. Develop innovative means of delivering programming for educational and general information/entertainment purposes. (For example, the Nebraska Educational Television Network's videodisc project which is exploring the uses of videodisc technology in interactive education and other services.)

These and many other public television services will not be overtaken by the private sector, nor will public television be able to find non-federal "alternative" means of supporting them entirely. In short, to do its job well public television will need continued adequate federal support, and can use increased federal funds, not only wisely, but in the national interest.

We understand and appreciate the need for economies in the federal government. Even so, OMB's recommended 1984 appropriation of $110 million would fall far below the minimum public broadcasting needs to continue providing high quality service; at that level, expansion would be out of the question. Therefore, we urge Congress to appropriate the maximum feasible amount for public broadcasting in 1984, in line with projections of non-federal support.

STATEMENT OF DENNIS FALK, GENERAL MANAGER, KFME, FARGO, N. DAK.

Mr. Carley. First, I'd like you to hear from the gentleman who was introduced so eloquently by Senator Burdick, Mr. Dennis Falk.

Mr. Falk. Thank you, Mr. Chairman. Senator Burdick, thank you very much.

Prairie Public Television operates four television stations serving most of North Dakota and northwestern Minnesota. We are building two additional stations in northwestern North Dakota which will also provide the first service to eastern Montana. We are also building the first public radio station in western North Dakota. We provide over 5,000 hours of program service a year to the people of North Dakota and Minnesota, and meet a variety of needs ranging from continuing education for food service workers to instructional programs used in schools throughout the area, from opera and symphony to "Grand Old Opry" and the University of North Dakota. We provide the only statewide media service.

North Dakota is the most rural State in the Union and there are no alternatives to the services that we provide. In an area with limited resources we take pride in the diversified support we have developed, including strong legislative and public support.

But let me explain what's happening to some of our funding sources. CETA funds—we have employed personnel who are scheduled for severe cutbacks. We received program funding through our State health department, scheduled for severe funding cutbacks. We have received funding from the State humanities council, the State arts council, and the State historical society, all scheduled for reduced funding. We received funding from numerous colleges and universities in our area and we work with over 22 institutions of higher education. We work with local school districts, the State board of higher education and the State department of public instruction. We have received funds from all those sources. Their discretionary funds are proposed for severe cuts. We have received direct support from the National Endowment for the Arts, scheduled for a 50-percent cut; from the National Endowment for the Humanities, scheduled for a 50-percent cut.

In addition, we rely very heavily for construction funds on the public telecommunications facilities program, of NTIA, scheduled to be completely eliminated.

The loss of those programs will also greatly increase the competition for funds from foundations, businesses. and our State legislature. Now those cuts alone would greatly impair our ability to serve the people of North Dakota and Minnesota. If, in addition, the discretionary funds we receive from the Corporation for Public Broadcasting are cut by 25 percent, we will be forced into major staff reductions. We will have to limit our broadcast hours and we will have to cut back in our program acquisitions.

If, at the same time, national program funding at the Corporation for Public Broadcasting is cut back, we will lose the major source of programing that generates those local contributions. Those national programs support our other services, the ones that I have described. You don't generate contributions with programs on continuing dental education or bookkeeping I. You do with "Live From the Met."

Now the end result could be a rapid downward spiral ending with the total loss of the one service that provides economical educational and cultural opportunities for everyone in North Dakota and northwestern Minnesota, a service that becomes even more vital as travel costs rapidly rise.

I'd like to bring this from the general to the specific. We often talk about our service and what we provide, but I think perhaps the best indication of what this service means to people is contained in one letter that I received taken out of many. This is in relationship to an exercise program we developed for the elderly called "Armchair Fitness." It's a local program. The hosts of it are Susan and El.

> Dear Susan and El: I must not wait any longer to tell you what your exercise program each day has done for me. I had so much pain in my hands, arms, and shoulders, especially after doing some housework, that I had my husband do the vacuuming and furniture polishing, et cetera. I couldn't lie on my shoulders at night because of the pain. After a couple weeks of doing regular exercise with you, my pain was disappearing and now I do my own vacuuming, furniture polishing and have even painted my kitchen and half my living room and bedroom and felt no bad effects after any of the jobs. You don't know how happy I am. I am 63 years of age, have always been active, and it was a big blow to me to have to give up some of the things I used to enjoy. You two deserve so much of the credit I tell everybody about you. Many thanks for making me relieved of my pain and for making each day so wonderful. I look forward to each morning. Sincerely, Mrs. Clem Sweeney.

Federal support for public television is an unqualified success. Few other Federal programs have stimulated local funding such as this one has. Much is accomplished at relatively low cost. Thank you for your past support. I urge you to strongly support continued funding for public television at the levels recommended by the National Association for Public Television Stations. Thank you.

Senator RUDMAN. Thank you very much, Mr. Falk.

Mr. CARLEY. Mr. Chairman, Mr. Ward Chamberlin, head of WETA, Washington, D. C.

STATEMENT OF WARD CHAMBERLIN, PRESIDENT AND GENERAL MANAGER, WETA PUBLIC TELEVISION, WASHINGTON, D.C.

Mr. CHAMBERLIN. Mr. Chairman, Senator Burdick, Dennis Falk has said it all very well as far as the effect of this rescission. This is a unique action with respect to public broadcasting which rescission will have on his station, and will affect all public stations throughout this country, although every public television station really is different and reflects the needs of the local situation in each community.

Here in Washington, we serve of course not only the District, but we serve to a large extent Maryland and northern Virginia. The effect the rescission would have on WETA is very severe and I could illustrate it in a couple ways.

For example, I gave my word to our viewers 2 years ago that if they contributed to WETA, the Federal Government this coming year would match their contributions with $1 for every $2 that they put in. That matching principle has been so effective in raising money for our local stations—it's the most effective thing you can do if you say to somebody if you put in $2 somebody else will put in $1, and that's what I told our viewers that 2 years ago. If the rescission goes through, why, my credibility and the credibility of our station is seriously jeopardized.

I would then just second what Dennis Falk says about the effect on programing. Our local programing at WETA, if there is a 25-percent rescission this coming year, will be drastically affected. Programs like "Town Meeting on the Air" which next week will deal with the educational situation in the District of Columbia, "Art Beat," and a number of our local news programs on radio will probably go off because we don't have enough unrestricted funds if those Federal funds are taken away starting this coming October. We have no time to adjust ourselves to that situation.

Therefore, the effect of the rescission on local programing throughout this country will be very severe.

It will also have an effect on national programing because we produce at WETA programs like the McNeil-Lehrer Report done out of our studios here every night of the week, "The Lawmakers," covering the Congress every week, "Washington Week in Review," and programs like that are bought by stations across this country. They are paid for with their unrestricted funds, and if those unrestricted funds are drastically cut quickly, it will make it impossible to keep the quality of programing that has enabled public television to report really the wonderful statistics that David Carley mentioned earlier, that two-thirds of the families in this country look at public broadcasting on a very regular basis. Thank you very much, Mr. Chairman.

Senator RUDMAN. Thank you, Mr. Chamberlin.

Mr. CARLEY. Mr. Chairman and Senators, the last person on our panel is Mr. Robert Larson, president and general manager of WITF of Hershey, Pa.

STATEMENT OF ROBERT LARSON, PRESIDENT AND GENERAL MANAGER, WITF, HERSHEY, PA.

Mr. LARSON. Mr. Chairman, members of the committee, I'm Robert Larson of WITF, the community public radio and television stations in Hershey serving south Pennsylvania, certainly Harrisburg, Lancaster, York, and Reading, and some of our programs reach Philadelphia, Senator Specter, and have already experienced one dramatic effect of the proposed rescission in funds for next year. We needed a new home because our landlord had sold the building in which we operated for 16 years. We made plans to relocate, decided to build, developed a workable budget and secured financing. We were about to let bids for construction and launch a capital campaign. Everything was ready for the final authorization.

Understandably, a responsible board of 45 citizens became nervous at the news about the proposed reduction in Federal funding. Carefully developed financial projections were now jeopardized. A tight, feasible budget would now have no margin for error with a 25-percent cutback.

In order to protect the vital program service for its 11-county community, this board voted to scrap the project. That's a good decision, but we know firsthand one effect of the proposed rescission.

What concerns us is that our good decision not to build was made in order to continue our local programing service in our State capital area. Even that is now in danger. The 25-percent cutback now threatens a daily electronic forum designed for public consideration of important issues.

For example, in November of last year, our station produced 18 consecutive nights of local programs focusing on the quality of education in our region through documentaries, call-ins, debates, live telecasts, reaching thousands of parents and teachers and young people and citizens. That is the kind of sustained effort that would be affected.

We have dealt with our cities, the relocation of Indochinese refugees, Three-Mile Island, nuclear energy, minority concerns, all in an in-depth fashion, something which public broadcasters both have an inclination and I believe a unique mandate to pursue. A cutback jeopardizes all that.

But there is one more concern that goes beyond the devastating impact of programing and service plans based upon the 1979 commitment that may be retracted in 1981. If we are to continue to examine difficult and sometimes controversial questions through programing that reflects the public interest in south central Pennsylvania, in spite of special interests or political interference, the ability to represent our publics and effect positive change without being compromised by the risk of control or influence through funding is essential for a vital public broadcasting service.

Those who have dealt with unpopular but essential community issues are familiar with clumsy attempts to constrain this public media. We have done what we can do to preserve viability of our stations. We cancelled the building project in order to protect programing. Now it seems that even the prospect of a vital, local programing service is threatened. Rescission threatens to make public broadcasting in our area vulnerable to political interference and it endangers the present base of public support by causing an unplanned and unexpected reduction in programing service, and that's what our public supports.

Throughout its short history, public broadcasting has been diagnosed as an institution that is too young, too conservative, too liberal, too cautious, too bold, but one does not recall the designation of being either too healthy or too public. Avoiding the proposed rescission I believe can help to keep public broadcasting in Pennsylvania and nationally both alive and public, serving the people who own and pay for it. Thank you.

Senator RUDMAN. Thank you very much.

Senator Specter, would you like to ask a question?

Senator SPECTER. Thank you very much, Mr. Chairman.

I was interested in your comment about the threat of political interference. Do you have anything specific in mind on that?

Mr. LARSON. What we have experienced in the past or what the rescission would foretell?

Senator SPECTER. Well, you commented that should funds be inadequate from the public sector you were fearful of political interference, and my question to you is, what specifically prompted you to make that statement?

Mr. LARSON. If the precedent is established, Senator Specter, that would cause funding to be victimized by a short-term funds, or political decisions related to the funding mechanism on a year-by-year basis, then our programing indeed could be threatened.

As it is now, where we have a 3-year advance appropriation, we can make plans and we are shielded from the kind of political activity which might have an impact upon our programs.

Senator SPECTER. Has there been a suggestion of any sort that a decision on funding was to be made based upon your programing with respect to political content?

Mr. LARSON. In the past there has been.

Senator SPECTER. What?

Mr. LARSON. One can recall the vote on the Corporation for Public Broadcasting funds in an earlier year, 1972 or 1973, where indeed because of programing that was presented nationally we did not make various politicians happy.

Senator SPECTER. Anything since then specifically?

Mr. LARSON. No; not since then, because we have been protected, as we should be protected, by a long-term authorization and advance appropriation which enables us to make programing plans without fear of political reprisal or political interference.

Senator SPECTER. Well, I think this subcommittee and any committee generally of the Congress would be very much concerned if funding did turn on political considerations. So if anything comes to your attention specifically in that regard, I think it would be very sensitive and very important to be received by this committee. Thank you very much, Mr. Chairman.

Mr. CARLEY. Mr. Chairman, could I add to that comment if I may?

Senator RUDMAN. You may respond.

Mr. CARLEY. First of all, Senator, I would like to say that there seems to be absolutely no evidence of any ideological thrust on the part of the administration or those who support rescission with regard to harming public television from a political interference or political caprice, as I said before you came in. So that is on the record. But it is also on the record that in 1971 the Public Broadcasting Service was informed that all news broadcasts and public affairs were to be removed or there would be absolutely no money.

Senator SPECTER. When was that?

Mr. CARLEY. 1971. There's little question about the fact that hearings on Watergate in 1972 and 1973 prompted a good deal of response on the part of the administration, some of which Mr. Larson has spoken to. We want to go on record as saying there is no evidence at this point of any ideological thrust against public television with regard to rescission. I think personally it was totally a political decision made solely with regard to Federal budget cuts.

However, $1 of rescission—$1 actually cut by rescission or the rescission procedure—says that perhaps tomorrow night or next year or the year after the $1 removed might very well come from an act of political program design rather than just fiscal cutting—and I'm talking about the intimidation question—and so it was this Congress that brought about and innovated the idea of advance money.

Senator RUDMAN. Let me just say to you that I am very familiar with the history of what you're talking about and you make very good sense. There is unquestionably a risk in a publicly funded broadcasting or press operation of any kind for political interference, but it really doesn't join the issue very well with the problems that we are confronted with to say that because this possibility exists, then somehow there must be, if not total immunity, at least partial immunity from the budgetary constraints the Federal Government is operating under at this time. That does not join the issue as far as I'm concerned. It raises a potential problem, but it does not join the issue.

The issue that we face is an issue of national distress over the state of our economy and we hear you speak here this morning—and I'm a great personal fan and supporter of public television in New Hampshire and have been for years and think we should try to support you to the greatest extent possible—but I think we have to understand that we are faced with human problems that we have heard here of a very compelling nature that need addressing, and to simply say that because this possibility exists of political interference that somehow that logically leads to either total or partial immunity to budgetary restraints, in my view, does not join the issue, although it raises a legitimate point.

Senator Burdick.

Senator BURDICK. Thank you, Mr. Chairman.

One thing that comes through to me this morning is your zealous desire to give the public a service and free yourselves completely from outside influences and be independent. Am I right?

Mr. CARLEY. Absolutely.

Mr. CHAMBERLIN. Yes.

Senator BURDICK. And that shortage in funding may cause you to adopt programs that might not preserve that independence; is that correct? I'm thinking of other methods of financing.

Mr. FALK. That's right.

Senator BURDICK. I understand that it's been estimated that one out of every four television viewers supports these programs through financial contributions by themselves, so you've got the public involved. What steps are being taken to capture more of this viewing audience?

Mr. FALK. Senator, if I may, we are working very diligently to increase the participation by the public. Obviously, our pledge week going on in most areas at this time is an example of that. We also utilize direct mail and other services. The public has responded very well.

A point that I would like to make is that a critical element in the funding of public broadcasting is the maintenance of the balance between a variety of sources. I think you can readily develop a scenario where, were Federal funding reduced and we were forced to rely too heavily upon contributory funds, we would very quickly develop a popularized program service that would increase the audience and hence generate more contributions from that audience.

In my mind, that kind of service, depending totally upon or largely upon individual contributions, would be as detrimental a service to the public as a program service that was totally dependent upon Federal funds. We need that balance. The Federal funds give us the opportunity to provide less popular programs. We will continue to generate funds from the audience, but I think we have an obligation to provide service to people whether they are providing funds or not. That's one of the strengths of public broadcasting.

Senator BURDICK. Well, if this rescission is approved by the Congress, what are you going to do? Are you going to reduce your services? Are you going to go to advertising?

Mr. FALK. In our case, Senator, we would most certainly—the first thing to go simply because of the flexibility or lack of flexibility of funds—the first thing that would go would be local program service. That means local people put out of jobs. We would reduce our staff severely. The next thing that would happen would be to reduce the number of hours we're on the air. Each hour that we cut back in our case is about $400 that we would save. Following that, we would reduce our acquisitions of outside programing and that, I think, would end up in ultimately reducing the contributory funding that we receive. That outside programing generates those contributory funds. It would have a severe effect.

Senator BURDICK. In other words, it's your opinion that the quality of your present programing would go down?

Mr. FALK. It would go down very rapidly I'm sure.

Senator BURDICK. Thank you, Mr. Chairman.

Senator RUDMAN. Do you have any other comments?

Mr. CARLEY. Respectfully, Mr. Chairman, you said our arguments today have not joined the issue. May I take a second to join the issue?

Senator RUDMAN. By all means.

Mr. Carley. Our argument against rescission, Mr. Chairman, with regard to the insulation argument, was not the only argument we brought up today. We pointed out that a good deal of money comes on the basis of a contract between the U.S. Congress and the administration in the past in terms of forward funding appropriation for 1982 and 1983. This was in fact a pretty solemn contract and an appropriation toward public television for all America.

On the basis of that commitment by this Government toward public television, these stations have already contracted for, as of this date, over $30 million in the station program cooperative, for the purchasing of programs in America, and within a few weeks it will be over $40 million, purchasing programs from one station to another, known as the cooperative.

So on the basis of that program, these contracts have been made.

In addition to that, the planning that I spoke of, and I didn't take much time from the committee, but there can be a more complete record made of the long-range planning that one must inevitably make for planning in public television in order to produce the kind of quality, both local, regional, and certainly at the national level, kind of programing there.

One last thing I'd like to say, sir, and that is this; that public television has not asked to be exempt from the budgetary process. Individually and personally, I must say I agree with exactly what you said with regard to the concern of this Congress, of this Senate, and of this committee, with regard to the matter of inflation and the economy in America today and doing something about it, and I applaud this committee and what it's doing and what the Senate and the House are doing.

It is true therefore that we have not asked for exemption from the budgetary process. We have said to Senators and Congressmen that we expect to be reviewed in as tough, realistic, and perhaps as critical a manner as any other agency or funding beneficiary of the U.S. Government in our 1984 budget. Most of the discussion, of course, in the newspapers which is going on in this arena—it really is about the fiscal year 1983 budget. We have appropriations for 1982 and 1983.

We ask on the basis of the other arguments we made to keep those fiscal year 1982 and 1983 funds, but to be reviewed as critically as you care possibly to do with regard to 1984. We do not expect and do not want to be exempt from that review.

Senator Rudman. I want to just insert in the record that Senator Pressler had intended to be here this morning to deliver a statement on impact aid, and he can't get here. So we will, without objection, enter his testimony in the record.

Well, I want to thank all of you for the quality of your testimony this morning. It's been very informative and particularly interesting to hear from all of you, but in particular I think from you who run the stations who essentially are on the firing line in telling us what this will do to you. I can assure you that the committee will give very careful consideration to what you have said here this morning and in the experience of what we are trying to do we will try to be of some help. Thank you for coming.

Is Congressman Coelho here, of California? I understand you have a statement that you would like to present to us this morning.

STATEMENT OF REPRESENTATIVE TONY COELHO, 15TH DISTRICT, CALIF.

Mr. COELHO. Thank you, Senator; yes, I do.

Mr. Chairman, I first off would like to introduce my assistant, Miss Chris Cleery, who is my expert in this particular area. In case you have any questions I may want to seek her advice.

Second, what I would like to do is submit my statement for the record and just take the pertinent parts of it that I would like to spell out to you this morning.

Senator RUDMAN. Without objection, that will be entered in the record after your oral presentation, and we do appreciate your summarizing your statement because we have a great deal to do, as I'm sure you do on the other side.

Mr. COELHO. Mr. Chairman, I appreciate this opportunity to appear to express my support for adequate funding for the National Institute of Neurological and Communicative Disorders and Stroke for fiscal year 1982. I support these additional fundings for NINCDS at the level of $340 million rather than the $276 million figure requested by the President.

I am here this morning to voice my support for the additional money. My endorsement of the coalition's position on this and my strong concern about the work of NINCDS stem from my association with both the Epilepsy Foundation of America and NINCDS as a member of the National Implementation Task Force of the Commission on the Control of Epilepsy and Its Consequences. My membership on that task force came about because I have epilepsy. I am one of some 2 million individuals in this country who have epilepsy and whose lives have been greatly and positively affected because of the fine work which has been done and which must continue through research at NINCDS to determine the causes of and develop new controls for epilepsy. Federal financial support for this research has been and remains vital, constituting the bulk of research support available. The private sector will not do more with regard to the development of antiepileptic drugs due to the simple fact that these drugs serve a population which is just not large enough, and I might say thankfully, to make research on these drugs profitable. The Federal role in supporting research on these drugs and on many other so-called orphan drugs, which can save and improve many lives yet which benefit a relatively small population, must not be reduced. Much has been done, but much remains to be done.

When we take into consideration the fact that just to test and market one new antiseizure drug it can cost $70 million, it becomes very evident that the available moneys do not stretch very far. Even the $276 million sought by the President is not adequate to allow for inflation nor to allow for some growth to enable the funding of some very promising research projects which could lead to breakthroughs in treating and preventing neurological disorders.

I want to stress, Mr. Chairman, that OMB has indicated that the inflation growth would be about 9.5 percent, and regards to NINCDS and the request that we are asking the additional amount of money wouldn't even come to that 9.5-percent inflation factor.

If your subcommittee can see fit to approve the optimal funding level of $340 million for NINCDS which has been advocated, I am confident those moneys will constitute a sound investment.

I know full well that you will have a difficult time parceling out moneys this year and your panel is under great pressure to be fair as well as to reduce Federal spending. Those of us who have come before you asking for more moneys for the various Institutes of NIH realize that you have a monumental balancing task weighing over you, but I would reiterate what others have already pointed out. If we spend just a bit more to support additional research, treatment, services, rehabilitation, and job placement programs, we will save a great deal in terms of reduced budget for welfare or social security or medical benefits which would otherwise have to be spent to support many individuals disabled due to illness or injury.

You had a witness before your panel who had arthritis and through the benefits she receives from NIH, et cetera, that she was able to get off dependence of the Federal Government and then be productive and be able to produce taxes, which is substantially beneficial. Hers is just one example. If we consider epilepsy alone, we are dealing with a disorder which costs the Nation some $3 billion per year in terms of lost tax revenues because of underemployment and unemployment, costs for treatment, and disability benefits. We must spend a little more to further our efforts to conquer a disorder which is costing us that much.

Again, Mr. Chairman, I thank you for the opportunity to testify in support of a continued and adequate investment in the well-being of so many lives and in the overall well-being of our society and, as I pointed out, because of my experience and background with epilepsy, I am heavily involved in all these particular activities and can speak with some experience and knowledge as to the benefit of these programs and how it can be beneficial to the Federal Government.

Senator RUDMAN. Congressman Coelho, let me point out to you that—I'm sure you know these figures, but so I understand your testimony—the Reagan budget was $276 million for fiscal year 1982, the Carter submission was $281 million. The continuing resolution for 1981 was $254 million. The figure you speak of as $340 million, which would be a 23-percent increase over present funding levels with the inflation rate that is being estimated by the administration at 12 percent, so that would be a real increase in dollars, that $340 million figure.

Mr. COELHO. I won't argue with you.

Senator RUDMAN. Let me say to you, Congressman Coelho, that we very much appreciate your coming across the Capitol this morning to give us your testimony from your personal vantage point. I can assure you we will give it very serious consideration.

Mr. COELHO. Thank you, sir. I appreciate it.

[The statement follows:]

STATEMENT OF REPRESENTATIVE TONY COELHO

MR. CHAIRMAN, I APPRECIATE THIS OPPORTUNITY TO APPEAR TO EXPRESS MY SUPPORT FOR ADEQUATE FUNDING FOR THE NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE FOR FISCAL YEAR 1982. WHILE I WILL FOCUS MY REMARKS ON FUNDING FOR NINCDS, I AM HERE, ALSO, TO VOICE MY SUPPORT FOR CONTINUED FUNDING FOR OTHER PROGRAMS WITHIN THE PURVIEW OF YOUR SUBCOMMITTEE WHICH PROVIDE SERVICES, TRAINING, JOB PLACEMENT, REHABILITATION, AND WHICH OTHERWISE FOSTER INDEPENDENT LIVING FOR THOSE WHO HAVE DISABLING OR DEBILITATING HANDICAPS OR PHYSICAL DISORDERS.

EARLIER THIS WEEK YOU RECEIVED TESTIMONY FROM MANY PUBLIC WITNESSES AND MEDICAL PROFESSIONALS WHO ARE VITALLY CONCERNED ABOUT OUR FEDERAL SUPPORT FOR RESEARCH AND FOR PROGRAMS TO SERVE THE ILL AND THE DISABLED, NOT ONLY TO MAKE THEM FINANCIALLY PRODUCTIVE CITIZENS BUT ALSO TO ENHANCE THE QUALITY OF THEIR LIVES. AMONG THOSE WITNESSES WERE REPRESENTATIVES OF A COALITION OF ORGANIZATIONS WORKING TO COMBAT DISEASES AND DISORDERS OF THE BRAIN AND CENTRAL NERVOUS SYSTEM WHO TESTIFIED IN SUPPORT OF ADDITIONAL FUNDING FOR NINCDS AT THE LEVEL OF $340 MILLION RATHER THAN THE $276 MILLION FIGURE REQUESTED BY THE PRESIDENT.

I AM HERE THIS MORNING TO VOICE MY SUPPORT FOR THE ADDITIONAL APPROPRIATION. MY ENDORSEMENT OF THE COALITION'S POSITION ON THIS AND MY STRONG CONCERN ABOUT THE WORK OF NINCDS STEM FROM MY ASSOCIATION WITH BOTH THE EPILEPSY FOUNDATION OF AMERICA AND NINCDS AS A MEMBER OF THE NATIONAL IMPLEMENTATION TASK FORCE OF THE COMMISSION ON THE CONTROL OF EPILEPSY AND ITS CONSEQUENCES. MY MEMBERSHIP ON THAT TASK FORCE CAME ABOUT BECAUSE I HAVE EPILEPSY. I AM ONE OF SOME TWO MILLION INDIVIDUALS IN THIS COUNTRY WHO HAVE EPILEPSY AND WHOSE LIVES HAVE BEEN GREATLY AND POSITIVELY AFFECTED BECAUSE OF THE FINE WORK WHICH HAS BEEN DONE AND WHICH MUST CONTINUE THROUGH RESEARCH AT NINCDS TO DETERMINE THE CAUSES OF AND DEVELOP NEW CONTROLS FOR EPILEPSY. FEDERAL FINANCIAL SUPPORT FOR THIS RESEARCH HAS BEEN AND REMAINS VITAL, CONSTITUTING THE BULK OF RESEARCH SUPPORT AVAILABLE. THE PRIVATE SECTOR WILL NOT DO MORE WITH REGARD TO THE DEVELOPMENT

OF ANTIEPILEPTIC DRUGS DUE TO THE SIMPLE FACT THAT THESE DRUGS SERVE A POPULATION WHICH IS JUST NOT LARGE ENOUGH (THANKFULLY) TO MAKE RESEARCH ON THESE DRUGS PROFITABLE. THE FEDERAL ROLE IN SUPPORTING RESEARCH ON THESE DRUGS AND ON MANY OTHER SO-CALLED "ORPHAN DRUGS," WHICH CAN SAVE AND IMPROVE MANY LIVES YET WHICH BENEFIT A RELATIVELY SMALL POPULATION, MUST NOT BE REDUCED. MUCH HAS BEEN DONE, BUT MUCH REMAINS TO BE DONE.

EPILEPSY IS JUST ONE OF MANY NEUROLOGICAL DISORDERS ON WHICH NINCDS RESEARCHERS ARE WORKING. MUCH PROGRESS IS ALSO BEING MADE ON AUTISM, STROKE, HUNTINGTON'S DISEASE, MULTIPLE SCLEROSIS, AND OTHER LESS KNOWN CONDITIONS--SOME 600 IN ALL--WHICH AFFECT THE BRAIN AND CENTRAL NERVOUS SYSTEM. WITH ITS PRESENT BUDGET OF $254 MILLION, OBVIOUSLY, NINCDS CANNOT UNDERTAKE MUCH OF THE WORK WHICH COULD BE DONE WERE MORE RESOURCES AVAILABLE. WHEN WE TAKE INTO CONSIDERATION THE FACT THAT JUST TO TEST AND MARKET ONE NEW ANTI-SEIZURE DRUG IT CAN COST $70 MILLION, IT BECOMES VERY EVIDENT THAT THE AVAILABLE MONIES DO NOT STRETCH VERY FAR. EVEN THE $276 MILLION SOUGHT BY THE PRESIDENT IS NOT ADEQUATE TO ALLOW FOR INFLATION NOR TO ALLOW FOR SOME GROWTH TO ENABLE THE FUNDING OF SOME VERY PROMISING RESEARCH PROJECTS WHICH COULD LEAD TO BREAKTHROUGHS IN TREATING AND PREVENTING NEUROLOGICAL DISORDERS. IF YOUR SUBCOMMITTEE CAN SEE FIT TO APPROVE THE OPTIMAL FUNDING LEVEL OF $340 MILLION FOR NINCDS WHICH HAS BEEN ADVOCATED, I AM CONFIDENT THOSE MONIES WILL CONSTITUTE A SOUND INVESTMENT.

I KNOW FULL WELL THAT YOU WILL HAVE A DIFFICULT TIME PARCELING OUT MONIES THIS YEAR AND YOUR PANEL IS UNDER GREAT PRESSURE TO BE FAIR AS WELL AS TO REDUCE FEDERAL SPENDING. THOSE OF US WHO HAVE COME BEFORE YOU ASKING FOR MORE MONIES FOR THE VARIOUS INSTITUTES OF NIH REALIZE THAT YOU HAVE A MONUMENTAL BALANCING TASK WEIGHING OVER YOU, BUT I WOULD REITERATE WHAT OTHERS HAVE ALREADY POINTED OUT. IF WE SPEND JUST A BIT MORE TO SUPPORT ADDITIONAL RESEARCH, TREATMENT, SERVICES, REHABILITATION AND JOB PLACEMENT PROGRAMS, WE WILL SAVE A GREAT DEAL IN TERMS OF REDUCED BUDGET FOR WELFARE OR SOCIAL SECURITY OR MEDICAL BENEFITS WHICH WOULD OTHERWISE HAVE TO BE SPENT TO SUPPORT MANY INDIVIDUALS DISABLED DUE TO ILLNESS OR INJURY. AS ONE WITNESS WHO HAD ARTHRITIS POINTED OUT TO YOUR PANEL, BECAUSE OF THE FEDERAL SUPPORT FOR PROGRAMS WHICH HAVE ALLOWED US TO MAKE HEADWAY IN BATTLING ARTHRITIS, SHE NOW CONTRIBUTES $12,000 PER YEAR TO THE FEDERAL COFFERS IN THE FORM OF TAXES SHE PAYS ON HER SALARY. NO ONE CAN DENY THAT IT IS MORE COST-EFFECTIVE FOR HER TO BE SELF-SUPPORTING THAN FOR HER TO BE SUPPORTED BY OTHER TAXPAYERS, DRAWING MONEY FROM THE FEDERAL COFFERS IN THE FORM OF SOCIAL SECURITY DISABILITY OR OTHER BENEFITS. HERS IS JUST ONE EXAMPLE. IF WE CONSIDER EPILEPSY ALONE, WE ARE DEALING WITH A DISORDER WHICH COSTS THE NATION SOME $3 BILLION PER YEAR IN TERMS OF LOST TAX REVENUES BECAUSE OF UNDEREMPLOYMENT AND UNEMPLOYMENT, COSTS FOR TREATMENT, AND DISABILITY BENEFITS. WE MUST SPEND A LITTLE MORE TO FURTHER OUR EFFORTS TO CONQUER A DISORDER WHICH IS COSTING US THAT MUCH.

AGAIN, MR. CHAIRMAN, I THANK YOU FOR THE OPPORTUNITY TO TESTIFY IN SUPPORT OF A CONTINUED AND ADEQUATE INVESTMENT IN THE WELL-BEING OF SO MANY LIVES AND IN THE OVERALL WELL-BEING OF OUR SOCIETY.

SUBCOMMITTEE RECESS

Senator RUDMAN. The subcommittee will now stand in recess.

[Whereupon, at 10:40 a.m., Thursday, March 19, the subcommittee was recessed, to reconvene at the call of the Chair.]

MATERIAL SUBMITTED SUBSEQUENT TO HEARING

[CLERK'S NOTE.—At the instruction of Chairman Schmitt, the hearing record remained open for a period of time to accommodate those wishing to submit statements to be included in the published transcript.]

DEPARTMENT OF LABOR

JOINT STATEMENT OF JESSE W. FISHER, JR., MANPOWER DIRECTOR, COLORADO RIVER INDIAN TRIBES; LUCILLE ENCINAS, MANPOWER DIRECTOR, PAPAGO INDIAN TRIBE; ADELINE TRACEY, MANPOWER DIRECTOR, SALT RIVER-PIMA MARICOPA TRIBE; FRED FERRIERA, MANPOWER DIRECTOR, SAN CARLOS APACHE TRIBE; LINDA TANI, MANPOWER DIRECTOR, WHITE MOUNTAIN APACHE TRIBE; GUY SUEPTOKA, MANPOWER DIRECTOR, HOPI TRIBE; ROD DIXON, MANPOWER DIRECTOR, GILA RIVER INDIAN COMMUNITY; SHELDON STERN, GENERAL COUNSEL TO THE NAVAJO TRIBE; AND GRACE MCCULLAH, EXECUTIVE DIRECTOR, INDIAN DEVELOPMENT DISTRICT OF ARIZONA

We the Indian tribes of Arizona are deeply concerned with recent developments regarding proposed budget reductions in the DOL's CETA program. These reductions would have a catastrophic impact on the lives of every Indian in the State and result in economic devastation both on the reservations and surrounding communities.

Currently the Department of Labor, through the Office of Indian and Native American Programs, funds employment and training activities on every reservation in Arizona. These CETA programs provide employment and skills training to truly needy Indians to assist them in establishing economic self-sufficiency. Programs encompass a wide range of skills in areas such as agriculture, energy development, construction, mining, health care, natural resources development (e.g. forestry and game), law & order, tribal administration, and community development. The proposed cuts would place these successful programs in dire jeopardy.

Prior to 1975, unemployment statistics on the reservation were at 72%, staggeringly high and growing every year. There was little opportunity for our young people who left school with no hope for the future. Private sector employment opportunities simply do not exist on the majority of reservations in Arizona. Suicide rates, particularly among young people, were many times the national average.

Recognizing this situation, Congress found that there was a "compelling need for the establishment of comprehensive training and employment programs for members of these communities" which were essential to reducing economic disadvantage and advocating economic and social development in Indian communities". (95-524,302(a)). The CETA program was established to provide previously non-existant employment and training in vital areas so that Indian people could be gainfully employed. The goals were to establish viable reservation economies which gave the tribal members a sense of pride in their achievements and a positive view for the future. For the first time, tribes had a viable mechanism for getting their members off the welfare roles and into productive occupations.

CETA programs in Arizona currently employ approximately 47,000 Indians. The number of employees has grown dramatically from an average of a few hundered in the early years of the program. As the number of CETA employees has grown, unemployment rates have declined significantly to an average of 37%. It must be stressed that it is not the intention of the Indian program to be forever dependent on federal dollars. The entire thrust of this program is to achieve economic independence to provide skilled workers in every aspect of business, industry and agriculture. As the skilled labor force has grown, private investment has been stimulated and economic development has begun to be a reality.

One of the complaints about CETA programs is that they tend to discourage private sector employment. While this may be true in urban settings, reservations have never had a stable private sector economy. A principle reason has been the lack of skilled labor - CETA is meeting that need. A significant percentage of CETA trained workers have achieved positive placement goals and are employed in various occupations on the reservation.

Prior to CETA, reservation welfare roles were large. The welfare burden falls both on the state and the federal government through the BIA General Assistance Programs. CETA has resulted in the removal of a significant number of Indians from these rolls. As CETA succeeds in in providing training and encourages economic development, the need for federal subsidies will decrease. However, if CETA is cut, the responsibility on both the state and federal governments will increase with no signs of diminishing. The only hope to establish self-sufficiency is to provide tribes with the tools to provide a sound and viable reservation economy. CETA has been extremely successful in it's first five years of implementation in establishing the necessary programs to achieve these goals. We urge you to continue to assist in developing the necessary tools for success.

STATEMENT OF WILLIAM L. HEARTWELL, JR., EXECUTIVE VICE PRESIDENT, INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES

The Interstate Conference of Employment Security Agencies (ICESA) welcomes the opportunity to voice our urgent concerns with the members of the Subcommittee regarding the FY 1981 and FY 1982 budgets for the employment security system. The Interstate Conference is an organization whose members include the state employment security administrators from the 50 states, the Virgin Islands, Puerto Rico and the District of Columbia. As the individuals responsible for administering the unemployment insurance programs, the U.S. Employment Service, the labor market information program and a large number of other employment and training programs, we are dedicated to the continued proper and efficient operation of these valuable programs. In the statement to follow, we will address several essential issues facing our membership, especially in light of our commitment to contribute to America's economic recovery.

The Administration has proposed a major plan to bring about recovery in the American economy. These proposals offer many opportunities for the state employment security system to participate especially by increasing employment in the private sector, by providing detailed labor market information, by assisting workers seeking relocation opportunities, by contributing to programs providing tax incentives and by offering employment assistance to individuals receiving food stamps, welfare benefitsor other forms of income maintenance. The employment security system is, in fact, an in-place, mainstream delivery system which can accomplish many of the goals of the Administration. Additionally, our record of low cost and efficient operations, one of the best in the nation, should provide ample incentives to utilize the employment security system.

BASIC AIMS OF THE EMPLOYMENT SECURITY SYSTEM

The employment security system provides two fundamental strategies for assisting workers and employers in the United States. The heart of the employment security system is composed of the unemployment insurance programs in each of the 53 states and jurisdictions and the allied public employment service. The structure of the employment security system is unique among the many relationships between the federal, state and local governments. The philosophical nature of the relationship between the federal and state governments is one of partnership.

The federal government defines the broad parameters of the unemployment insurance system but each state or jurisdiction passes its own authorizing legislation establishing the state unemployment compensation program. In this fashion, each state's unemployment insurance system reflects the needs of the state's employers, workers and citizens. The federal government authorizes the existence of the public employment service to provide assistance to all "men, women and juniors" who are seeking jobs or other employment assistance. Through a system of approximately 2,500 local offices spread across the nation, the employment security system delivers both unemployment insurance and employment services, while collecting, analyzing and disseminating essential labor market information.

The employment security system is financed almost entirely (99 percent) through employer taxes. The unemployment insurance benefits claimants receive are financed entirely by the state employment taxes collected and dedicated to that purpose. Employers additionally pay federal employment taxes, authorized by the Federal Unemployment Tax Act (FUTA), which are committed to financing the administrative costs of the federal-state employment security system and to provide 50 percent of the costs of the extended benefits program (additional weeks of unemployment benefits available during periods of high unemployment). In addition, there is a small supplementation appropriated from federal general revenue which finances 3 percent of the costs of the Employment Service. The tenants of FUTA are that employers shall share in the costs of operating the unemployment insurance programs and the proportion of the Employment Service which equals the proportion of workers covered by unemployment compensation laws nationally (97 percent). To this end, programs administered by the employment security system which are financed through Social Security Title III grants-to-states funds should be those which directly involve the unemployment insurance programs or which assist in the location of workers for jobs and jobs for workers. Such odd activities as rural loan certification, migrant housing inspections and a myriad of other enforcement and compliance functions thrust on the employment security system are not consistent with the nature of its funding and its enabling legislation.

THE FEDERAL-STATE PARTNERSHIP

Through its years of existence, beginning in 1933, the employment security system has resounded rapidly and unfailingly to the directions set for the nation by both the Executive and Congressional branches of our federal government. In recent years, constraints placed upon the system by the federal partner, particularly within the Employment Service, have come alarmingly close to destroying this invaluable delivery system. These constraints have impaired the states from making the best use of the employment security system to enhance the economic conditions in their labor market areas.

Since the mid-1970s, there has been a significant decline in state participation in the federal-state partnership. We suggest that the very nature of this nationwide delivery system has made it both expedient and attractive for the federal partner to shift program emphasis and direction, through administrative means, in an attempt to correct the immediate economic or social concerns or to respond to political pressures. The constant redirection and changing focuses developed to meet the needs of various "target" groups have resulted in the employment security system having so many priorities for providing services that there are essentially no priorities. Rather than examining the broad social and economic configurations over the longrun, there has been an increasing tendency to inject quick fixes into the economy through the employment security and employment and training systems. A perfect example of this type of quick fix, expedient policy shift is found in the massive buildup of public service jobs (Title VI of CETA) in 1976.

An additional factor which has contributed to the erosion of the federal-state partnership lies in the creation of duplicative and overlapping employment and training programs. While we recognize that the Employment and Training Administration has been faced with an increasingly difficult management situation in trying to control several competing and overlapping employment and training programs, we no longer accept this as viable. The federal partner has never even been able or willing to clearly define the roles of each component in the several employment and training strategies available. Clearly, further federal administrative control with decreased state and local participation, will not accomplish the goals of increased private sector employment and economic recovery. If the new principle of state program control and responsibility is adopted by the federal partner, we believe a vastly improved employment and training community will emerge from under the current burden of Employment and Training Administration controls.

Lastly, the complex array of enforcement and compliance functions administered through the employment security system results in a massive diversion of resources and attention from the basic missions of the institution. In effect, the employment security system has been asked to carry out many chores which amount to policing either the private or public sectors to ensure they are complying with federal regulations and Executive Orders. An ICESA research project currently underway reveals that there are over 150 orders, regulations or other requirements with which the employment security system must ensure compliance of their own agencies or others, including businesses.

THE EMPLOYMENT SECURITY SYSTEM IN THE EIGHTIES

The Interstate Conference is convinced that the employment security system is a necessary component of a revised employment and training strategy which will be mobilized to meet the demands of reindustrialization and economic revitalization in the United States. The nation must ensure that an economic safety net is in place which stabilizes communities and individuals during periods of economic change. We cannot afford to simply write off existing underutilized or declining labor market areas as losses. Rather, we must be able to offer those labor market areas in decline the opportunity to shift from one outmoded economic/industrial mix to another, revitalized and productive economic/industrial mix.

Unemployment insurance provides one part of the necessary safety ~~net~~ that allows a community the time and basic economic stability to shift from one industrial mix to another. Furthermore, the association between the unemployment insurance system and the employment service, combined with the special worker protection programs, ensures that claimants can be automatically exposed to employment opportunities both locally and nationally. The employment security system is involved with ensuring that one basic resource, human capital, is protected and can become the vehicle through which human capital is identified, located, developed and moved to areas where it is needed most. However, this set of principles can only function if the employment security system is adequately financed and freed to accomplish its basic missions.

THE FY 1981 AND FY 1982 BUDGETS

The Interstate Conference is deeply distressed by the directions the Administration's budgetary analyses have taken, particularly in the last weeks. In our view, the development of the final Administration budget package has devolved from a programmatically knowledgeable approach to a strictly dollar reduction exercise. The stated goals of the Administration to increase private sector employment, to reduce the dependence of workers on unemployment insurance, of others on food stamps, and to design a workfare approach to welfare reform, flies in the face of the wholesale disintegration of both the employment security and the CETA systems. While both systems can be changed, they continue to offer many positive strategies for assisting individuals to find unsubsidized work which provides financial security for themselves and their families. At this point, if the Administration's program modifications and reductions are enacted in toto, we predict that the results will include, at a minimum, a significant increase in the unemployment rates and the number of welfare recipients. We do not believe this is consistent with the stated intentions of the Administration.

EMPLOYMENT SERVICE REDUCTIONS

The Administration has proposed a $150,000,000.00 reduction in the Employment Service state staffing level. In face of 16 years of standstill budgets which consistently have provided 30,000 staff years for the Employment Service, we cannot comprehend the logic of reducing this system by over 5,100 positions. The collision of this reduction with other modifications to staffing arrangements which will occur both within the CETA programs and the Disabled Veterans Outreach Program mean a nearly 30 percent impact on front-line Employment Service who are engaged in direct placement activities.

The Administration has repeatedly stressed that recipients of food stamps, welfare and unemployment benefits will be required to enter into mandatory work search activities. The Employment Service has, by law, administered the bulk of these work test activities and we assume the Employment Service will be charged with increased responsibilities for administering even tougher work test programs in the coming years. We would only point out:

- Local offices, particularly the smaller offices which are often the only labor market mediator in rural areas, will be closed due to the reduction in not only staff, but the overhead resources available. (The state administrators are now investigating which office leases can be broken, which areas can access other offices and so on. We are not able to provide an exact estimate on the number of offices which will close, but as the information is available, we will share it with the Subcommittee.)
- The loss of 20 to 25 percent of those staff directly engaged in placement activities may result in a 20 to 25 percent reduction in placements (approximately 1,000,000 lost).
- Individual placements could drop as follows:
    - Youth, down 412,366
    - Minorities, down 305,423
    - Economically disadvantaged, down 305,423
- The Employment Service has functioned at a standstill since 1966 placing about 180 persons yearly for each staff year involved directly in placement activities at a FY 1980 cost of approximately $152 per placement.
- Other services such as counseling and testing, job search assistance, job development and labor market information could take even deeper drops since most staff would have to be diverted to front-line activities.

- Services to new industry and new businesses will decline in order to assist the unemployed, the food stamp recipients, the welfare clients and the job seekers requesting assistance.
- The continued redirection, over-prioritization and diversion of staff to enforcement and compliance activities will result in even more drastic reductions in placements.

While the Interstate Conference believed that employment security activities and functions were basically those which would be supported by the new Administration, Secretary of Labor Raymond Donovan's press release indicated the following:

> "Employment Service grants to state employment security agencies (are reduced) by $150 million in fiscal year 1982, with comparable reductions in the following years, reducing the nationwide staffing level in state agencies from 30,000 to 25,000. While the Employment Service performs job matching service to workers without charge, in addition to other compliance functions, it services only a small portion of the labor market, often serving as a personnel office for the private sector or as a "backstop" for job seekers, who usually can find jobs through other means. This reduction is in line with President Reagan's emphasis on increased use of private sector mechanisms and reductions in government."

The Interstate Conference and its membership adamantly disagree with the statement and its implications. In the years since 1966 when the 30,000 staff ceiling was established, the labor force has increased by 42 percent. The Employment Service additionally has become the depository for functions which no other system can or is willing to accomplish, required through a morass of Executive Orders, regulations and legislation. Yet, in spite of all this, the Employment Service has consistently placed individuals in private sector employment at a generally increasing rate. Furthermore, when asked the Employment Service responded with resounding success to a new program, the Targeted Jobs Tax Credit program, by vouchering over 290,000 workers and certifying over 305,000 persons for tax credits in 1980. This work was accomplished with minimal funding which covered the costs of forms and program start-up.

The public employment service in many parts of the country is the only labor market mediator available to either employers or workers. Its ability serve more workers and more employers is a simple function of the willingness to provide adequate staffing, reduce the conflicting priorities and eliminate those functions which erode the basic missions of locating jobs for workers and workers for jobs. We implore the Subcommittee to reject the recommended reduction in Employment Service staffing and to direct the Employment and Training Administration to eliminate those functions that inhibit the basic mission of the Employment Service.

DISABLED VETERANS OUTREACH PROGRAM

This Disabled Veterans Outreach Program was made a permanent service program, providing special employment counseling and placement services to disabled veterans, last year by the Congress. Unfortunately, the issue of financing this program has not been adequately addressed and it is the intention of the Employment and Training Administration to require the more than 2,000 disabled veterans specialists required by law to be financed through Employment Service grants. Therefore, added to the reduction requested by the Administration, the Employment Service will be required to absorb out of its remaining staff, at least 2,000 more positions dedicated solely to services for disabled and Viet Nam era veterans. Furthermore, the Employment and Training Administration may require the Employment Service to begin absorbing these costs in the third quarter of FY 1981.

The Employment Service has a long and distinguished history of services to veterans and considers this part of its basic institutional mission. However, the financing for special veterans services programs, formally provided by CETA Title III grants, has never come from FUTA financed Employment Service grants before. To agree to the absorption of 2,000 DVOP specialists within the Employment Service grants-to-states funds is to say to the employers of the United States you must provide, through your federal employment taxes, special employment, counseling, and outreach services to veterans. This is not only inconsistent with the intentions of the FUTA laws, but we believe with the intentions of those who supported P.L. 96-466 establishing a permanent Disabled Veterans Outreach Program.

We strongly urge the Subcommittee to recommend separate general revenue financing for the Disabled Veterans Outreach Program, thus preserving the integrity of the FUTA financing structure for the employment security system.

UNEMPLOYMENT INSURANCE REDUCTIONS

The last recommendation we wish to address involves the 3 percent productivity assessment recommended for the unemployment insurance system. Essentially, the Administration is requiring that 3 percent more work be accomplished with the same amount of resources. Since unemployment insurance costs are justified through one of the most sophisticated, tightly monitored cost modeling devices in the federal or state arena, we cannot agree with the recommendations to impose a productivity assessment of this type. Additionally, in light of the recent legislation to impose federal suitable work requirements on extended benefit claimants and the proposed legislation to do the same for claimants in the regular program after 13 weeks, reductions in the unemployment insurance staffing levels are not consistent with the increased workload items. Additionally, if the Employment Service staffing were to be reduced to the proposed level, a reduced unemployment insurance staff would not be capable of fulfilling all of its duties. Therefore, we urge the Subcommittee to remove the requested productivity assessment and fund the unemployment insurance system at its fully justified level.

CONCLUSION

The Interstate Conference recognizes that the nation faces extraordinary challenges in the next several years. We are supportive of serious and detailed analyses of programs, the methods of their operation and their costs. However, before programs are defunded to the point of non-existence, it is clear to us that there should be some measurement of their worth to the nation and their role in improving the economic climate. If it is determined that a program is ineffective because it is over regulated, the improvements recommended should be to deregulate the program, not destroy it to get rid of the over regulation. We cannot accept that programs which have created jobs and provided training for millions of Americans are totally unsalvageable.

Many of the state employment security agencies administer parts of CETA programs or operate as prime sponsors for parts of their states. We believe that some elements of CETA offer many useful and successful programs which should not be administratively dissolved through "consolidations" which resemble a modified form of block granting to prime sponsors. We are especially concerned that this consolidation is being undertaken essentially without Congressional advice and review.

In summary, we urgently request the restoration of $150,000,000.00 to fund the Employment Service at the 30,000 staff year level, and request that Employment and Training Administration be required to remove non-essential functions which erode the basic missions of our institution. Additionally, we implore the Subcommittee to prevent the Employment and Training Administration from requiring the FUTA financed Employment Serivce to absorb the costs of the Disabled Veterans Outreach Program by requesting general revenue financing for this program. Lastly, we strongly recommend the Subcommittee finance the unemployement insurance system at its fully justified level, thereby insuring that sufficient staff and resources will be available to meet the needs of the unemployed.

The Interstate Conference is grateful to the Subcommittee for this opportunity to discuss our concerns and make recommendations on behalf of the 53 state employment security agencies. The staff of the Interstate Conference pledge their assistance to the Subcommittee in responding to any additional questions which may be raised during its deliberations.

DEPARTMENT OF EDUCATION

STATEMENT OF GANADO PUBLIC SCHOOLS, GANADO, ARIZ.

The Ganado Public School District appreciates this opportunity to present testimony to the Subcommittee regarding two Federal programs that are of vital concern to the educational future of our school district and our children. These two programs are the school construction assistance program, authorized pursuant to P.L. 815, and the maintenance and operations program, authorized pursuant to P.L. 874, of the Federal impact aid program.

The Ganado Public School District is located in the south central portion of the Navajo Reservation in the north eastern corner of Arizona. The School District is approximately 950 square miles and the school facilities and operation is located in the town of Ganado. Most of the 1600 children attending Ganado Public Schools are Navajo, most of whom come from Kinlichee, Klagetoh, Cornfields, Stamboat and Ganado, the five Navajo Chapters within the jurisdiction of the school district. The Navajo-Hopi Joint Use Area abuts the district boundary and a small number of Hopi children from the Toyei area attend the Ganado schools.

Because the school district encompasses Indian lands, the tax base is inadequate for the financial, and therefore educational, needs of the children. One of the problems that arises from the Federal policy of exempting Indian land from taxation is the forced reliance on other sources of revenue. Ganado Public Schools can not rely on the traditional method of property taxation to raise sufficent revenue to provide a quality education for all its children. A direct consequence for Ganado is the pressing need for school facilities.

The overcrowded conditions that exist at the Ganado schools are significantly limiting the educational opportunities for our students. The junior high school provides a pointed example. The junior high school building was designed and constructed for a capacity of 200 students. There are currently 583 children crowded into this facility. Additionally, the district is unable to provide appropriate science and physical education programs because of a lack of a proper gymnasium or science lab. Many students at Ganado must attend classes in the approximately 50 substandard portable classrooms. These temporary classrooms have heating and cooling problems that occasionally force the cancellation of scheduled classes due to the difficulty heating these units in the winter and cooling them in the summer, when temperatures often reach 96°. Recently, the Board of Education commissioned an "Education Program Status Report" to survey the District's educational program. The Report recited the educational difficulties caused by its inadequate facilities. This Report noted:

> "Just as in the case of the Junior High School, the educational program of the Senior High School suffers because the physical plant has never been completed, and because so much of the program is housed in temporary and widely scattered facilities. The program suffers in a number of important ways. The temporary nature of many of the facilities has several implications, e.g., instructional spaces are generally too small, inadequately heated or cooled, lacking equipment or improperly located . . . . . And the very fact that some facilities are missing altogether means that programs . . . are either not conducted at all or conducted under the most tenuous and strnuous of conditions."

The report also found that the doubling of uses that a facility was used for , i.e. junior and senior high classes, caused problems arising from the intermingling of younger children with older students.

The Ganado Public School District has on file with the Department of Education an application for a grant to provide needed minimum school facilities for children residing on Indian lands and for inadequately housed children, Section 14, P.L. 815. This P.L. 815 program is authorized to assist school districts like Ganado who have no other method of meeting capital construction needs. The program has a backlog of unfunded applications from prior years. Beginning in 1967, the Department has not received adequate approriations to allow funding of all pending applications. The rising costs of school construction has had a dual effect on the program by making it harder for public school districts on Indian lands to pay for new construction out of local resources and by limiting the number of projects that the Department was able to fund. There are hundreds of millions of dollars of Section 14 applications pending in the Department of Education.

Accordingly, Ganado Public School District is requesting that this Subcommittee meet the urgent need for school facilities for Indian children. The District requests that the Subcommittee appropriate $101 million to begin to reduce the backlog of applications for Section 14 school construction grants. Unquestionably, this amount of money will not fund all the construction needs in all the public schools serving Indian students. However, this level of appropriation would take a big first step in meeting the Federal obligation to Indian children.

The Ganado Public School District is not only concerned about buildings, we are also concerned about educational programs. As the Subcommittee knows, the Reagan recommendation for the operations and maintenance portion of the Federal impact aid program calls for a reduction in funding for districts serving children from Indian lands. Ganado Schools would lose 10% of its operational money derived from impact aid, if Congress approved the FY81 rescission. The FY82 recommendation would reduce all "A" payments by 10%. Ganado implores this Subcommittee to continue to fund "A" category children at the full entitlement. The school district receives no tax benefit from "A" children and is forced to depend on Federal assistance to support their basic educational programs. Any reduction in funding would reduce the chances of our students receiving a full educational program at Ganado.

In 1978, the Congress established a Presidentially appointed Commission on the Review of the Federal Impact Aid Program. Its charge was to assess the merit and equity of impact aid assistance. During the course of its deliberations, the Commission studied the financial condition and educational difficulties of public schools operating on Indian lands. The Commission made the following recommendation: [that]

> "Congress recognize that the United States has a special and unique obligation with respect to the education of Indian children which arises from treaties between the United States and Indian tribes and that the impact aid program is one of several means by which the United States can, in part, statisfy that obilgation. . . ."

This recognition of a "special and unique" relationship" between Indian people and the Federal government is consistent with recent Congressional and Executive policy. The Congress is aware of the difficulties that face Indian people in general. We submit that education opportunity is one way to correct the problems that Indian children face in our society. In this, we of Ganado Public Schools are quite conservative in our approach. Our Board of Education has set as the school districts overriding objective the conservation of the potential of our children. We request that Congress give us the tools to education the children in our community. Because of the unique relationship that our school has to the Federal government our program is completely dependent on Federal funding. The fact is inescapable. Since we have a small and insufficent tax base we must depend on impact aid for our construction and program funds. We urge the Subcommittee to appropriate adequate funding to allow us to teach our children in school facilities suited to their educational needs.

STATEMENT OF THE AMERICAN HISTORICAL ASSOCIATION

The American Historical Association, a nonprofit professional organization concerned with the promotion of historical studies and active in promoting women's history, appreciates the opportunity to submit this testimony in support of the Women's Educational Equity Act (WEEA) Program's current $10 million budget under the FY 81 continuing resolution.

The purpose of WEEA is to "provide educational equity of women in the United States" through the award of grants and contracts to public agencies, private nonprofit organizations and individuals. These awards are to be used in developing educational materials and model programs designed to promote women's educational equity. The materials and programs are prepared for replication throughout the United States.

Since the first funding in 1976, WEEA has supported the incorporation of women-related materials into the established elementary, secondary and postsecondary education curriculum. One of the difficulties women have had toward achieving equal status has been the invisible nature of their history. The preparation of curriculum materials for the inclusion of women into history is regarded by the AHA as a step toward overcoming this difficulty. WEEA's support through small grants programs for the incorporation of the scholarly research and methodology of women's history into all educational levels has fostered a more complete and affirmative presentation of women's history, essential toward the attainment of educational equity for women.

The impact of the WEEA program is far in excess of the amount funded as many programs are suitable for replication. Continued appropriations for this small but highly visible and effective program are recommended.

STATEMENT OF HON. LARRY PRESSLER, U.S. SENATOR FROM SOUTH DAKOTA

MR. CHAIRMAN: I am pleased to have this opportunity to testify before the Labor-H.H.S.-Education Appropriations Subcommittee on behalf of the 49 South Dakota school districts, 5,015 category "B" students, and 8,026 category "A" students who receive federal impact aid. As you well know, the appropriations for this program have been under attack for many years. And the often unclear regulations for receiving impact aid monies has resulted in a continual struggle and uncertainty of funds for many South Dakota schools.

South Dakota has a particularly large number of schools located on or near Indian reservations with large Indian populations. In addition, Douglas Schools System, which is located on Ellsworth Air Force Base near Rapid City, South Dakota, was identified by the President's Commission on Impact Aid as an illustration in which economic burden definitely exceeds the support. Many of these school districts, such as Todd County

SCHOOL DISTRICT LOCATED ON ROSEBUD INDIAN RESERVATION IN SOUTH-CENTRAL SOUTH DAKOTA, ARE APPROXIMATELY TWO-THIRDS NON-TAXABLE INDIAN LAND. THE PRIMARY INDUSTRY IN THESE AREAS IS AGRICULTURE WITH VERY LITTLE INDUSTRIAL DEVELOPMENT. UNEMPLOYMENT IS EXTREMELY HIGH AND MANY OF THE JOBS THAT DO EXIST ARE FUNDED BY FEDERAL PROGRAM MONEY, NAMELY CETA, THAT ARE ALSO BEING JEOPARDIZED. ANOTHER UNIQUE CHARACTERISTIC OF THESE SCHOOLS ON THE INDIAN RESERVATION IS THE SPARSITY FACTOR. FOR EXAMPLE, TODD COUNTY SCHOOLS MUST TRANSPORT 75% OF THEIR STUDENTS DAILY OVER 1,734 MILES OF BUS ROUTES.

IN FISCAL YEAR 1981, DOUGLAS SCHOOL SYSTEM AT ELLSWORTH AIR FORCE BASE HAS A PROJECTED LOSS OF $251,386.00 BASED ON THE 10% RECISSION. THE BOARD HAS ALREADY INDICATED THAT THEY WOULD BE UNABLE TO COMPLETE THE 1981-82 SCHOOL YEAR.

HAVING SERVED ON THE SENATE BUDGET COMMITTEE DURING 1979 AND 1980, I STRONGLY SUPPORT THE GOAL OF A BALANCED BUDGET. AND I BELIEVE THAT SOME SACRIFICES MUST BE MADE BY ALL AMERICANS IN OUR EFFORT TO RESTORE AND REVITALIZE OUR ECONOMY. HOWEVER, ELIMINATING IMPACT AID TO MANY SCHOOL DISTRICTS DOES NOT MEAN A SACRIFICE IN TERMS OF REDUCING STAFF OR DISCONTINUING PROGRAMS, BUT RATHER, THE POSSIBLE CLOSING OF THESE SCHOOLS. FOR, UNLIKE MOST FEDERAL CATEGORICAL ASSISTANCE, IMPACT AID IS USED FOR GENERAL OPERATING EXPENSES.

THERE IS NO QUESTION THAT THE FEDERAL GOVERNMENT HAS A RESPONSIBILITY TO THE STUDENTS IN THESE SCHOOLS. THE FEDERAL OWNERSHIP OF PROPERTY REDUCES LOCAL TAX INCOME FOR SCHOOL PURPOSES AND A FEDERAL PROJECT OR ACTIVITY CAUSES AN INFLUX OF PERSONS INTO A COMMUNITY, RESULTING IN AN INCREASED NUMBER OF CHILDREN TO BE EDUCATED. HOWEVER, THE DEGREE OF THIS RESPONSIBILITY IS THE CONSIDERATION. LOSS OF IMPACT AID FUNDS WOULD BE DEVASTATING TO MANY SCHOOL DISTRICTS FOR:

(1) THERE WOULD BE NO MEANS OF REPLACING LOST REVENUE. THESE DISTRICTS ARE BEING TAXED TO THE MAXIMUM.

(2) THE SCHOOLS ARE ALSO RECEIVING $200 MORE PER PUPIL FROM STATE SOURCES THAN THE NON-IMPACT AID STUDENT

IN THE STATE -- THUS THE STATE IS MEETING ITS RESPONSIBILITY.

HAVING SERVED ON THE EDUCATION AND LABOR COMMITTEE DURING MY YEARS IN THE HOUSE OF REPRESENTATIVES, I REALIZE THAT MAINTAINING EQUAL EDUCATIONAL OPPORTUNITIES IS A DIFFICULT OBJECTIVE. HOWEVER, IMPACT AID REPRESENTS THE BASIC EDUCATION FOR STUDENTS ON FEDERAL LAND, AND I HOPE THAT FAVORABLE CONSIDERATION CAN BE GIVEN TO APPROPRIATIONS FOR THESE SCHOOLS.

STATEMENT OF DR. PATRICK J. McDONOUGH, ASSOCIATE EXECUTIVE VICE PRESIDENT AND DIRECTOR, PROFESSIONAL AND GOVERNMENTAL AFFAIRS, AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION

My name is Patrick J. McDonough and I am the Associate Executive Vice President of the American Personnel and Guidance Association. APGA is a national professional organization of over 41,000 guidance, counseling, and student personnel workers serving children, youth and adults through educational and rehabilitation settings, and community and private agencies. The Association is comprised of thirteen national divisions and 54 State Branches (including District of Columbia, Puerto Rico, Latin American and European branches).

My recommendations for Supplemental funding in Fiscal Year 1981 as well as funding in Fiscal Year 1982, as they relate to guidance and counseling programs are contained in the attached documents. Where there are increases recommended over last year's appropriations, these are modest and attempt to continue and maintain existing services taking into consideration inflation. I ask that these statements be included in the record of this hearing. Rationale sheets for each program's funding recommendations are attached as appendices to this statement. In addition, a summary of the requests is synopsized on the first page after this cover sheet.

Today, Mr. Chairman, I'd like to deviate from the prepared statements to protest vigorously the Reagan Administration's March 11 rescissions, revisions, and block grant proposals cutting drastically vitally needed education and rehabilitation funding for Fiscal Year 1981 and 1982. It appears that human resource programs and other federal spending programs are to bear the brunt of this nation's inflationary ills. There doesn't seem to be much evidence that the Reagan announced revisions, aside from their obvious dramatic and pplitical impact, will have any real effect on reducing inflation. In fact, some data proposes just the opposite with the net effect being an additional tax burden on state and local government (see attachment 1), plus a reduction of services and the creation of a new unemployment category, educational and health personnel plus to reduce school and human service budgets.

In addition to the faulty economic logic connected with the Reagan revisions, the targets of his revisions and rescissions in education programs appear to be the poor, the weak, the helpless, minorities and the future of this country. To be specific, in the area of guidance and counseling programs (an integral program facilitating the education, mental health and social welfare processes of this country), the following was recommended:

1. The continued rescission in FY'81 of $18 million of already appropriated State grant funds for Title IV-D, Guidance, Counseling and Testing and no recommendation of continuance for Fiscal Year 1982.
2. A reduction in funding, through the block grant concept, for career education at the elementary and secondary level and no funding of postsecondary career education programs.
3. A rescission of $195 million in vocational education programs for FY'81 and $156 million recommended decrease for FY'82. Vocational guidance is an integral part of this program.
4. A recommended shift, consolidation and reduction in funding for Rehabilitation Services programs by placing it in a Social Services block grant, administered by the Department of Health and Human Services in Fiscal Year 1982.
5. The elimination of all funds, $10 million for Section 504 of the Rehabilitation Services amendments which removes artificial and employment barriers to those handicapped seeking an education.
6. Education Outreach Programs, Title I of the new higher education programs have a zero funding recommendation for FY'82. This vital program meets the continuing education and referral needs of youth and adults in a technological society.
7. The effective elimination of emphasis on equal opportunity for women through a proposed rescission of $2.5 million in FY'81 and reduction in funding and merging of this program in a state block grant in FY'82.

Attachment 1

PROPOSED REAGAN ADMINISTRATION REDUCTIONS IN ELEMENTARY AND SECONDARY EDUCATION AND SCHOOL LUNCH PROGRAMS FOR FY 82

State	Estimated Federal Education Expenditure FY 1982	Elementary and Secondary Education 25% Cuts[1]	School Lunch Program Cuts[2]	Total Additional Tax Burden on STATE and LOCAL GOVERNMENTS[3]
Alabama	$ 160,354,000	$ 40,089,000	$ 20,342,000	$ 60,431,000
Alaska	64,618,000	16,155,000	1,407,000	17,562,000
Arizona	164,496,000	41,124,000	12,293,000	53,417,000
Arkansas	125,310,000	31,328,000	12,183,000	43,511,000
California	1,577,595,000	394,399,000	64,082,000	458,481,000
Colorado	32,734,000	8,184,000	15,804,000	23,988,000
Connecticut	103,727,000	25,932,000	13,411,000	39,343,000
Delaware	46,267,000	11,567,000	2,727,000	14,294,000
District of Columbia	43,941,000	10,986,000	1,104,000	12,090,000
Florida	307,813,000	76,954,000	42,173,000	119,127,000
Georgia	281,148,000	70,287,000	35,886,000	106,173,000
Hawaii	66,007,000	16,502,000	6,835,000	23,337,000
Idaho	48,732,000	12,184,000	6,225,000	18,409,000
Illinois	861,466,000	215,367,000	40,570,000	255,937,000
Indiana	126,857,000	31,715,000	38,677,000	70,392,000
Iowa	96,542,000	24,136,000	25,799,000	49,935,000
Kansas	62,735,000	15,684,000	16,308,000	31,992,000
Kentucky	157,295,000	39,324,000	22,492,000	61,816,000
Louisiana	278,121,000	69,531,000	26,429,000	95,960,000
Maine	51,160,000	12,790,000	6,365,000	19,155,000
Maryland	154,911,000	38,728,000	19,591,000	58,319,000
Massachusetts	260,872,000	55,218,000	32,789,000	98,007,000
Michigan	422,539,000	105,635,000	39,567,000	145,202,000
Minnesota	136,662,000	34,166,000	31,634,000	65,800,000
Mississippi	226,731,000	56,683,000	10,735,000	67,418,000
Missouri	203,100,000	50,775,000	29,599,000	80,374,000
Montana	40,739,000	10,185,000	4,960,000	15,145,000
Nebraska	54,751,000	13,688,000	10,890,000	24,578,000
Nevada	25,020,000	6,255,000	3,664,000	9,919,000
New Hampshire	18,094,000	4,524,000	5,767,000	10,291,000
New Jersey	157,400,000	39,350,000	26,203,000	65,553,000
New Mexico	89,688,000	22,423,000	5,793,000	28,216,000
New York	401,480,000	100,370,000	49,582,000	149,952,000
North Carolina	343,922,000	85,981,000	36,289,000	122,270,000
North Dakota	21,252,000	5,313,000	4,973,000	10,286,000
Ohio	273,070,000	68,268,000	58,399,000	126,667,000
Oklahoma	154,021,000	38,506,000	16,525,000	55,031,000
Oregon	139,989,000	34,997,000	13,417,000	48,415,000
Pennsylvania	531,844,000	132,962,000	62,143,000	195,105,000
Rhode Island	22,324,000	5,582,000	2,678,000	8,260,000
South Carolina	173,875,000	43,469,000	16,705,000	60,174,000
South Dakota	39,256,000	9,814,000	5,191,000	15,005,000
Tennessee	271,223,000	67,806,000	24,865,000	92,671,000
Texas	673,453,000	168,364,000	65,575,000	233,939,000
Utah	58,513,000	14,629,000	13,208,000	27,837,000
Vermont	13,835,000	3,459,000	2,891,000	6,350,000
Virginia	222,560,000	55,640,000	32,061,000	87,701,000
Washington	183,687,000	45,922,000	17,409,000	63,331,000
West Virginia	93,799,000	23,450,000	10,524,000	33,974,000
Wisconsin	158,352,000	39,588,000	28,134,000	67,722,000
Wyoming	19,970,000	4,993,000	2,937,000	7,930,000
U.S. and D.C.	$10,234,755,000	$2,560,982,000	$1,095,808,000	$3,656,790,000

NOTE: Totals may not add due to rounding.

[1] This value was computed using NEA's *Estimates of School Statistics*, a publication in its 39th year. Data reported in the publication are provided by state education departments.

[2] Estimated cuts for FY 82 in School Lunch Program

[3] This column represents the estimated amount of revenue which must be made up by state and/or local governments for the cost of educating the children.

March 6, 1981

Attachment 2

Summary of the American Personnel and Guidance Association
FY 1981, 1982, 1983 Funding Requests

A. FY'81 Rescinded Appropriations -- Education

1. P.L. 95-561, Education Amendments of 1978, Title IV, Part D, Guidance, Counseling and Testing -- $18 million

B. FY'82 Appropriations -- Education

1. P.L. 95-207, Career Education Incentive Act
   - Sec. 4 State Grants -- $15 million
   - Sec. 11 Postsecondary -- $12 million
2. P.L. 56-561, Education Amendments of 1978, Title IX, Part C, Womens Educational Equity -- $20 million
3. P.L. 96-374, Education Amendments of 1980, Title I, Part B, Higher Education, Education Outreach Programs -- $15 million
4. P.L. 94-482, Education Amendments of 1976, Title I, Vocational Education, Part A, Subpart 3, Program Improvement and Support Services, Section 134, Vocational Guidance and Counseling - $162 million
5. P.L. 95-561, Education Amendments of 1978, Title IV, Part D, Guidance, Counseling and Testing -- $18 million supplemental appropriations to this 1981 forward funded program for FY'82.
6. P.L. 95-602, Rehabilitation Act Amendments of 1973 as amended, Section 504 -- $10 million

C. FY'83 Appropriations (Forward Funding) -- Education

1. P.L. 95-561, Education Amendments of 1978, Title IV, Part D, Guidance Counseling and Testing -- $20 million

D. FY'82 Appropriations -- Rehabilitation Services

1. P.L. 95-602, Rehabilitation Act Amendments of 1978, Title I, Vocational Rehabilitation Services, Part A, Section 101, General Provisions. -- $945 million
2. P.L. 95-602, Rehabilitation Act Amendments of 1978, Title I, Training, Section 114 -- $45 million
3. P.L. 95-602, Rehabilitation Act Amendments of 1978, Title II, Research, Section 204 -- $45 million

Attachment 3

FY 1982 Appropriations

Public Law 95-207, Career Education Incentive Act

Section 4, State Grants
Section 11, Post Secondary Educational Demonstration Projects

A. Background:

The Career Education Incentive Act was signed into law on December 13, 1977. Its purpose is to assist states, local educational agencies and institutions of postsecondary education to make education a preparation for work and a means of relating work values to other life roles and choices. A contextual thread throughout this legislation is the importance of guidance and counseling in the implementation of career education programs at the state, local and postsecondary levels.

Essentially, the "Career Education Incentive Act" plans to institutionalize a new philosophy of education within a five-year period. This legislation expands and broadens the federal role initiated by the Career Education Special Projects Act of the Education Amendments of 1974, P.L. 93-380. It is entering into its fourth year of authorization.

Emphases of this program include:

- inservice training of all educational personnel in career education practices
- curriculum revisions
- elimination of sex role stereotyping
- business, labor, education and private organization cooperative planning
- comprehensive career guidance, counseling, placement and follow-up services
- occupational and career information dissemination and evaluation
- career education demonstration projects at the postsecondary level

B. Funding:	Section 4	° Requested	$15 million
		° Authorized -	$50 million
		° Reagan Budget	Consolidation
	Section 11	° Requested	$12 million
		° Authorized	$15 million
		° Reagan Budget	Consolidation

C. Rationale:

1. $15 million for State Grants is needed as it takes more money to implement programs than plan them. The intent of P.L. 95-207 is to institutionalize career education in the schools. This level of appropriation for state grants will help accomplish this.

2. Students moving from secondary institutions to postsecondary need continued emphasis and development of their career educa-

tion plans. In addition, research on why students go to and stay in college (ACT study) show they do so for career related reasons. Yet many college and university faculties are not in touch with the ever-changing and complex labor market. The $12 million for Section 11, Postsecondary Programs, would provide the bridge between these two entities and insure continuity of career development planning.

3. Regular postsecondary students and adult second careerists are most in need for education about the world of work in order to ready themselves to compete in the labor market. Section 11 has never been funded since the inception of the Act. The National Advisory Council on Career Education meeting in Washington, D.C., on September 15, 1980, identified funding of Section 11, Postsecondary Programs as a top priority.

4. This program in its entirety is targeted for consolidation by the Reagan Administration, except for $150,000 as a national information effort at the Federal level. This frustrates the intent of Congress in institutionalizing career education across the United States.

Attachment 4

FY 1982 Appropriations

Public Law 95-561, The Education Amendments of 1978

Title IX, Additional Programs

Part C, Women's Educational Equity

A. Background:

The Women's Educational Equity Act originally was a part of the Special Projects Act of P.L. 93-380, the Education Amendments of 1974. Its primary purpose is to promote educational equity for women and girls at all levels of education. The program funds grants and contracts for developmental, demonstration and dissemination projects of national significance and also provides funds to local projects which reduce sex discrimination in individual school districts and other educational institutions. In 1978, the Women's Educational Equity Act was incorporated into Title IX of P.L. 95-561. This Act has many guidance and counseling implications particularly in the development of nondiscriminatory training and counseling programs as well as sex fair testing materials.

B. Funding:

	° Requested	$20 million
	° Authorized	$80 million
	° Reagan Budget	Consolidated

C. Rationale:

1. While education is primarily a state and local responsibility, equality of opportunity is a federal responsibility. Gains made by women, minorities and disabled individuals within our educational system have not been the result of either state or local initiatives but rather of a federal response to national mandates to address issues of discrimination in our society.

2. Educational opportunity and equity for girls and women is economic good sense as the United States then taps the intellectual potential of all its citizens to maximize their achievement. Girls and women have been a neglected resource in this maximization of intellectual potential.

3. Effective counseling and guidance are essential ingredients in providing girls and women educational parity but more emphases is needed on the elimination of possible sex discriminatory practices and testing instruments. Appropriate counseling helps women and girls be better aware of their personal strengths and weaknesses, and the values and skills sought by potential employers.

4. The $20 million appropriation is sought to continue important developmental, dissemination and demonstration grants but also, for the first time, emphasize local significance grants which help bring local institutions into compliance with Title IX of the Act.

Attachment 5

FY 1982 Appropriations

Public Law 96-374, The Education Amendments of 1980

Title I, Higher Education

Part B, Education Outreach Programs

A. Background:

Educational Outreach Programs are designed to provide comprehensive information programs and for adults whom educational needs have been inadequately served during youth or whose age, sex, race, handicap, national origin, rural isolation or economic circumstances may be a barrier to such opportunities. Specifically, Educational Outreach Programs are organized to provide educational information, guidance, counseling and referral services. Their purpose is to combine the efforts and activities of professional and lay groups, communities, private and public agencies and local, state and federal governments to consolidate activities into a multipurpose and accessible program and to mobilize the resources that impact on educational needs.

B. Funding:

°	Requested	$15 million
°	Authorized	$30 million
°	Reagan Budget	0

C. Rationale:

1. The importance of Education Outreach Programs is to insure that service in continuing education will be better achieved through increased emphasis on planning and coordination which more effectively uses existing resources of both public and private sectors.

2. Vitally needed job placement, guidance and counseling, referral services and tutorial assistance is made accessible to residents of rural and urban communities through this new program.

Attachment 6

FY 1982 Appropriations

P.L. 94-482, The Education Amendments of 1976

Title I, Vocational Education

Part A, Subpart 3, Program Improvement and Supportive Services
Section 134, Vocational Guidance and Counseling

A. Background:

Program Improvement and Supportive Services provides funds for: Applied research, operation of exemplary and innovative programs, curriculum development, development of innovative instructional materials, guidance and counseling services, training of vocational education personnel, and assitance to schools to overcome sex-stereotyping in occupational areas. Section 134 provides that not less than 20% of the funds available under this subpart go to support vocational guidance and counseling. The funds are made available to states to provide "expansion and improvement of the vocational and career guidance and counseling systems." The statutorily recommended guidance program and service activities include such things as "(1) initiation, implementation and improvement of high quality vocational guidance and counseling programs and activities; (2) vocational counseling for children, youth and adults, leading to a greater understanding of educational and vocational options; (3) provision of educational job placement service...; (4) ...training designed to acquaint guidance counselors with (several items related to overcoming sex-stereotyping)..." and so on.

B. Funding:		
	° Requested	$162 million (not less than 20% for guidance and counseling)
	° Authorized	$297 million
	° Reagan Budget	$ 99.6 million

C. Rationale:

1. Increased costs for vocational education programs and runaway inflation mandate this modest increase for Subpart 3 programs of 22%. Vocational guidance funding in the state program improvement and support servicd programs comprises not less than 20% of each state's Subpart 3 funds. Vocational guidance is central to effective vocational education.

2. Effective vocational education and vocational guidance programs are important means of reducing youth and adult unemployment.

3. A strong vocational guidance component in vocational education increases the individuals' job-seeking and job-retention skills.

4. Research indicates that vocational education programs are more successful and cost effective with a strong vocational guidance and counseling component.

5. Work experience during high school tenure, combined with counseling in job interview skills, personal behavior and dues, working with authority figures and developing job contact networks were significantly associated with securing immediate past high school employment, regardless of vocational skill level.

Attachment 7

FY 1981 Rescinded Funds
FY 1982 Supplemental Appropriations
and FY 1983 Advance Funding

P.L. 95-561, The Education Amendments of 1978

Title IV, Educational Improvement, Resources and Support
Part D, Guidance, Counseling and Testing

A. Background:

Title IV-D was established to assist states and local educational agencies to improve their guidance and counseling programs and services. The provisions of this title include:

1. providing state leadership and supervisory services in the fields of guidance, counseling and testing;

2. grants to states for comprehensive guidance, counseling and testing programs in elementary and secondary schools.

Allocations for funds to states and local jurisdictions are by student population (ages 5-17) formula or competitive grants at an individual state's discretion.

The implementation of programs under this title has in fact assisted LEAs and SEAs to add and refine their guidance programs. Special impetus has come for comprehensive guidance programs at the elementary and middle school/junior high levels.

B. Funding:

	FY 1981 Rescinded Funds	FY 1982 Supplemental	FY 1983 Advance Funding
° Requested	$18 million	$18 million	$20 million
° Authorized	$50 million	$50 million	$50 million
° Reagan Budget	0	0	0

C. Rationale:

1. In order to more adequately meet the needs of students across the country in all grade levels, increased dollars are needed. We are seeking increased dollars to assist the states and LEAs as well as for funds to be increased at the federal level to be used for the identified discretionary purposes. There are still needs for additional staffing in counseling and guidance programs; we are talking about changed roles for the counselors, and guidance staffs that are in place and thus, there is an increased need for staff development; better program planning, designing, implementing, and evaluating is beginning, and increased dollars would better enable us to do that; better research is needed so that districts can be better convinced that dollars spent in these activities are essential to better learning of their kids.

2. Through the impetus of this money, several trends are being brought to fruition which further enhance schools' abilities to meet students' needs: Development of comprehensive, developmental guidance curriculum; increased use of paraprofessionals.

3. The general public continues to place increased demands on schools to meet students' personal, social, and career needs, thus more money to expand the program is necessary.

4. The $18 million has not increased at all in ten years and yet inflation has. Considering the impact of inflation, then guidance and counseling is in a standstill-back-up position, and maintenance of program efforts is not even possible.

Public Law 95-602, Rehabilitation Act Amendments of 1978

Title I, Vocational Rehabilitation Services

Part A - General Provisions, Section 101 (For Basic Rehabilitation Programs)

A. Background:

The purpose of this title is to authorize grants to assist States to meet current and future needs of handicapped individuals in order that such persons may prepare for and engage in gainful employment to the extent of their capabilities.

B. Funding:		
	Requested	$945,000,000 (For FY'82)
	Authorized	$945,000,000
	Reagan's Budget	$900,000,000

C: Rationale:

Full funding is recommended since it is needed to provide direct rehabilitation services to handicapped youth and adults, In addition, funds are needed to meet the priority of serving the severely handicapped. It is generally recognized that it costs from two and one-half times more money to rehabilitate a severely disabled individual as compared to the non-severely disabled individual. This shift in priorities necessitated an adjustment by VR Agencies in that fewer people can be rehabilitated for the same amount of money. When inflation is taken into account, the end result is really less money to utilize for case services to the handicapped. For the past four years total numbers of rehabilitations have been dropping. To decrease funds in this area when inflation is taking a bigger bite each year and while trying to serve the more severely disabled client is an ineffective way to continue the process of rehabilitation that converts unemployed person into taxpayers.

During the past years of its 59 year history the State-Federal partnership has rehabilitated and placed more than 4.6 million people in jobs During FY'79 alone, this nationwide program served 1,127,551 handicapped persons, A decrease of 3.6% from the previous year and rehabilitated 288,376 disabled people. Against this record of success, it is estimated that an additional six million Americans could benefit from the rehabilitation program.

For Basic State Grants to meet current and future needs of handicapped individuals in order that such person may prepare for and engage in gainful employment, the recommended appropriation is $945,000,000.

It should be noted that the Basic Service Program will be funded at a level indexed to the Consumer Price Index ($880 million in FY'80 as the base year) up to a maximum authorized ceiling of $945,000,000. Assuming the maximum authorized amount of $945 million, the Basic State Rehabilitation Services Program would only receive an increase in funding of 7.4% over the FY'80 level of $880 million. Due to this factor the requested and authorized amount of funding will merely insure that vital services are maintained at the FY'80 level.

Public Law 95-602, Rehabilitation Act Amendments of 1978

Title I, Training

Section 114

A. Background:

Under this authority, the Rehabilitation Services Administration may make grants to an contracts with States and public or nonprofit agencies to pay part of the costs for training of professionals, traineeships and inservice training of teachers involved in teaching the deaf.

B. Funding:		
	Requested	$45,000,000
	Authorized	$45,000,000
	Reagan's Budget	$25,000,000

C. Rationale:

The full authorization level for FY'81 is $45 million. As with other programs annual appropriations have not kept pace with inflation, and in addition Training Programs have been severely shortchanged over the past three years. This cycle of lower appropriations must be broken if we are to continue to attract and train new talent to provide the wide range of rehabilitative workers needed, e.g. the rehabilitation process needs more occupational therapists, psychologists, mental health professionals, rehabilitation counselors, nurses ,etc. The shortages in staff such as rehabilitation medicine prosthetics and orthotics are well known and without additional funding critical staff shortages will occur which can only hamper the effectiveness of the rehabilitation programs stimulated by the Act itself.

Forty-five million dollars is recommended to continue programs and to initiate new and innovative training of professionals. The need to develop the manpower tc provide adequate rehabilitative services is imperative.

It is important that the Rehabilitation Services Administration's training funds be targeted at geographical areas of greatest need. Those areas , isolated or rural, which have shortages of different types of health professionals . There is a critical need for the agency to develop and implement guidelines for the allocation of training funds, based on data relating to rehabilitation needs of certain populations and the supply of health professionals to meet their needs.

Public Law 95-602, Rehabilitation Act Amendments of 1978

Title II, Research

Section 204 (Research)

A. Background:

This section established a National Institute of Handicapped Research (NIHR) to oversee federal assistance to rehabilitation research, NIHR has authority over a program of demonstration centers to develop the employment potential of severely handicapped individuals.

B. Funding:

Requested	$45,000,000
Authorized	$90,000,000
Reagan's Budget	$35,000,000

C. Rationale:

The Research programs under the National Insititute of Handicapped Research (NIHR) are an essential link to the rehabilitation process. in that new approaches and methodology are being sought to effectively rehabilitate persons, Prior to the establishment of NIHR, this activity was the Research component of RSA.

The Research efforts of this Institute are designed to identify and help eliminated the causes and consequences of disability on personal and family concerns as well as mental, social and vocational and economic effects disability may have on a person.

The program presently supports 22 Rehabilitation Research and Training Centers ("R&T Center") (12 medical, 3 mental retardation, 3 vocational, 3 mental health, and 1 independent living), 16 Rehabilitation engineering centers, and a substantial numbers of research projects in medical social, mental health, and vocational rehabilitation. The new (FY1980) R&T Centers have been established to focus upon rehabilitation of the aged disabled, independent living and mental illness. New projects have focused upon the prevention of disability in children and rehabilitation of burn victim among other areas.

The additional funding requested will enable the Institute to begin a number of research projects in the areas of the rehabilitation of children, rehabilitation techniques to deal with deafness, and low vision, and technology fevelopmentand distribution. In addition, the increase will support the creation of two model service centers required by statute for rehabilitation pf pre-school children and vocational placement of the severely disabled, and will also support increases for those of the 22 R&T Centers which have had their real program support reduced during the past two years. Most all new projects and centers supported are likely to be jointly funded with other federal agencies just as many of the 1980 project were; e.g., NIMH joint funding in areas of mental health, NIH-NIA and AoA joint funding of aging projects and VA and NASA joint funding of technology development and distribution activity.

Public Law 95-602, Rehabilitation Act Amendments of 1978

Title II, Research

Section 204 (Research) continued

It is recommended that forty-five million dollars be appropriated for the continued support of this much needed work in an area to critical need.

Attachment 11

FY 1982 Appropriations

Public Law 95-602, The Rehabilitation Act of 1973, as Amended

Section 504

A. Background:

Section 504 of the Rehabilitation Act of 1973 is designed to eliminate discrimination on the basis of handicap in any program or activity receiving federal financial assistance. This includes prohibition of such discriminatory actions as denying, participating in or benefiting from any federal aid benefit or service that is afforded to non-handicapped individuals.

Emphases of this program include:

- employment practices
- prgoram accessability
- free and appropriate preschool, elementary and secondary public education
- postsecondary education; including admissions, recruitment,housing, access financial assistance.
- health, welfare and social services

B. Funding:

	° Requested	$10 million
	° Authorized	$10 million
	° Reagan Budget	-0-

C. Rationale:

1. Handicapped individuals, children, youth and adults, deserve equal opportunity to free and appropriate elementary, secondary and post-secondary education.

2. Section 504, as a Civil Rights law which imposes non-discrimination requirements on all recipients of federal financial assistance, deserves federal support just as other federal civil rights laws are supported.

3. Costs of education at all levels are escalating geometrically, therefore compliance with Section 504 without federal support is burdensome.

Section 504 of the Rehabilitation Act of 1973 is designed to eliminate discrimination on the basis of handicap in any program or activity receiving federal financial assistance. This includes prohibition of such discriminatory actions as denying participating in or benefiting from any federal aid or service that is afforded to non-handicapped individuals of this program include:

- employment practices
- program accessability
- free and appropriate pre-school, elementary and secondary public education
- postsecondary education; including admissions, recruitment, housing.access, financial assistance
- health, welfare, and social services.

STATEMENT OF NATIONAL ADVISORY COUNCIL ON WOMEN'S EDUCATIONAL PROGRAMS

The National Advisory Council on Women's Educational Programs is pleased to respond to the request for our views concerning the appropriation for Fiscal Year 1982 and the supplemental request for Fiscal Year 1981 for the Women's Educational Equity Act (WEEA) as amended in the Elementary and Secondary Education Amendments of 1978. The following statement was prepared on the basis of the budget submitted in January, on which the Subcommittee has been holding hearings, which differs sharply from the recently proposed budget. Nevertheless, the Council, a Presidentially appointed body, confirmed by the Senate, believes it is essential to share with the Committee our views based on five years of detailed knowledge of the WEEA Program. Council members, who come from all parts of the country, have visited many grant projects, met with beneficiaries as well as staff, analyzed reports, critiqued the products, and prepared an annual evaluation of the operation of the program, in accordance with our statutory mandate.

The Women's Educational Equity Act was initially passed in 1974 with an authorization of $30 million, designed "to provide educational equity for women in the United States" through grants and contracts to generate model strategies and replicable tools. Wisely, Congress expanded the mission of WEEA when it reauthorized the program in 1978. Congress recognized that the mammoth job of overcoming sex bias, discrimination, and stereotyping requires more than the development of models and tools. These new models and tools must be used and adapted to the specific needs of *local* school districts and individual educational institutions. Therefore, the WEEA authorization was increased and a second part (or "tier two") was established to be triggered when appropriations rise beyond $15 million. Tier two money will assist local school districts and other institutions in overcoming the barriers to equity and compliance with Title IX as they perceive them in their own communities.

The pending request for a $5 million supplemental appropriation for FY 1981 is intended to initiate the second tier by reducing to $10 million the ceiling for national and regional projects which are supported under tier one. The Advisory Council is eager for the local implementation phase of WEEA to get under way and we therefore ask that a start on tier two be made in the current year.

The request for an FY 1982 appropriation of $20 million is of even greater urgency. It will permit level funding of $10 million for tier one, allowing improved models and tools to be developed and disseminated. The second $10 million, 75% of which goes to local education agencies, would be used for overcoming sex bias and discrimination at the grassroots level.

If future generations of women are to escape the handicaps and limitations of sex discrimination and sex role stereotyping experienced by the current generation, we must use multiple approaches and strategies to effect change. Fortunately, many products of the earlier grants under WEEA are now available. Training modules for teachers and counsellors, career counselling materials, films and audio-visual materials for classroom use, projects to meet special needs of minorities and by-passed groups of women, model programs to help women into non-traditional vocational education programs and careers are now on the market and ready for use. To derive maximum benefit from the money invested to date in WEEA, these materials and many more must get into the hands of local schools, community groups, parent organizations, and community colleges who want help in their efforts to comply with non-discrimination laws and policies.

WEEA provides that recipients of these tier two funds must contribute toward support of the projects, so that local involvement and "ownership" is assured. Federal money can flow to a local project for no more than two years. Constructive help, in response to requests from local communities, is surely preferable to the enforcement mode for eliminating barriers to compliance with civil rights requirements. The Advisory Council strongly advocates this WEEA "carrot" so that the enforcement "stick" may become unnecessary.

The recent hearing on sex discrimination in the workplace, held by the Senate Labor and Human Resources Committee, highlighted the severe economic disadvantages still suffered by working women, despite years of equal pay and anti-discrimination legislation. Witnesses pointed to occupational segregation of women in traditional, low-paid, and often dead-end jobs as the major cause of their earning less than 60¢ for every dollar men earn. The Women's Educational Equity Act has funded a variety of projects which are aimed at this long-standing problem. Diverse projects, targeted at groups from pre-school children to the mature woman, help to widen horizons, build self-confidence and basic skills, and encourage individuals to maximize their opportunities. These projects can enable many women and girls to increase not only their individual options and earnings, but their productivity and contributions to the nation's economy.

The new budget proposes a 25% rescission from the Continuing Resolution level of $10 million. If this $2.5 million cut were sustained, the program could award no new grants this year. Over 800 applications--representing untold hours of planning, writing, working by nonprofit organizations, individuals, and education personnel--were submitted in January. In February some 90 readers, chosen to represent a variety of expertise, racial/ethnic background, geographic areas, age, handicap, and socio-economic level, devoted an intensive week to screening these proposals so that a handful of the best, designed to meet top priority needs, could be selected. To terminate this process at this point in the fiscal year would not be cost effective; it would be cruel!

Even if a supplemental appropriation cannot be supported for this austere year, we urge you to retain the level funding of the Continuing Resolution. If this small program must share in the general belt-tightening, let it be in FY 1982, with due notice to its broad constituency across the country. The Women's Educational Equity Act is a fine example of how Federal seed money and local implementation of a program can benefit millions of individuals, their communities, and thus the nation.

STATEMENT OF DR. JOHN M. DUNN, ASSOCIATE PROFESSOR, DEPARTMENT OF PHYSICAL EDUCATION, OREGON STATE UNIVERSITY

I am pleased to have the opportunity to provide a written statement concerning President Reagan's proposed budget and its potential effect on handicapped school age students. My statement reflects my various roles as a Professor, handicapped advocate, local school board member, and active professional in the field of special physical education. In short, the proposed budget submitted by the Reagan administration for fiscal year 1982 and the 25 percent rescission planned for fiscal year 1981 represents an unacceptable withdrawal of the federal commitment to the education of handicapped students. Specific concerns I have include the following:

(1) The proposed reductions would result in a decrease of the funds available through PL 94-142, from the Congress authorized 40 percent of national average per pupil expenditure (NAPPE) to less than 10 percent. As a concerned educator and local school board member, I can assure you that this is woefully inadequate. Given this reduced level of expenditure, handicapped students will not receive the quantity or quality of services specified under PL 94-142 and PL 93-112.

(2) The current proposal to consolidate programs into State Education Agency (SEA) and Local Education Agency (LEA) block grants threatens the foundation of handicapped legislation, specifically PL 94-142 and PL 93-112. If states and local school districts would have originally provided equal educational opportunities for the handicapped, PL 94-142 and PL 93-112 would not have been necessary. Sufficient testimony has been provided during the past ten years to justify my concern that SEA's and LEA's have not historically provided equal service to the handicapped. Therefore, to now make funds available in a block grant format to LEA's and SEA's without specification

as to the percentage of money which must be provided for each of the targeted purposes is unacceptable.

(3) The Reagan OMB budget proposal to reduce the related services which must be provided by the LEA is also unfortunate. A monitoring report by the Bureau of Education for the Handicapped (now Office of Special Education) noted that one of Oregon's most pressing needs was additional physical and occupational therapists to serve our handicapped students. Since that time, many of Oregon's LEA's have made a concerted effort to provide related services with the end result that Oregon's handicapped children have benefitted. For example, Portland Public School System's handicapped children now have for the first time a Portland Motor Development Team (PMDT) composed of 22 individuals providing needed related services. Without the initiative of PL 94-142, it is doubtful that this team would have been assembled. To eliminate the LEA requirement for related services will not eliminate the needs of Portland's handicapped students now served by the PMDT. The same can also be said of the number of recreational therapists providing valuable consultative services to school districts within Oregon as well as nationally.

(4) The proposed 25 percent rescission in the 1981 budget represents a particularly severe blow to the Office of Special Education personnel development grants. A fourteen million dollar reduction in training is not acceptable at a time in which school districts need the assistance of new appropriately trained personnel and opportunities for their staffs to receive inservice training in the education of handicapped students. As a recipient of grants provided by the Office of Special Education, I can assure you that our efforts have improved the physical education services available to Oregon's handicapped students. All of our training efforts are provided on site to school districts at no cost to participating districts. This year over 300 students have received services provided by personnel trained in our projects. While there is little direct financial return for the University (8% indirect rate) to provide these services, we are proud of our efforts to serve Oregon's handicapped students. Training needs must receive top fiscal priority if we are to provide the services required of school districts and their handicapped students.

Thank you for the opportunity to provide this statement. I would be pleased to respond to any follow-up questions which you might have concerning my observations.

STATEMENT OF JOHN H. MAXSON, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF WORKERS FOR THE BLIND

Mr. Chairman and members of the Subcommittee, the organizations submitting this joint statement have as their principal missions the promotion, development, and improvement of services to blind persons. The American Association of Workers for the Blind (AAWB) is a national membership organization of professional workers in the field of blindness. The National Council of State Agencies for the Blind (NCSAB) is an organization of representatives of state service programs involved in the prevention of blindness and the provision of vocational rehabilitation services to visually handicapped individuals.

We are distressed by the failure of the Administration to include blind and other disabled persons in its "safety net" of budgetary protections for the poor and elderly. In this connection we are most gravely concerned by, and strenously opposed to, the proposal to establish a "social services block grant", the plans for which include repeal of the Rehabilitation Act and the Developmental Disabilities Assistance and Bill of Rights Act; transfer of National

Institute of Handicapped Research funds to a "social services research" program, to be commingled at a reduced level with a variety of non-disability related discretionary activities; reducation of funding for the consolidated block grant programs by 25% in 1982; and elimination of any program policies and directions, earmarks or limitations in providing those funds to the states. Moreover, discretionary programs now administered under the Rehabilitation Act, such as independent living projects, projects with industry, special demonstration projects, the Helen Keller Center for Deaf Blind Youths and Adults, client assistance projects, facilities improvement grants, manpower training, training services, and program evaluation, all would be obliterated and combined with other block grant funds. Each of these programs contains projects benefitting blind and visually handicapped persons.

The Rehabilitation Services Administration, the Administration for Developmental Disabilities and other Federal entities would, under the Administration's proposals, be abolished. Funding for the rehabilitation programs for Social Security Disability Insurance and Supplemental Security Income would also be eliminated. Taken together, it is apparent that these proposals signal a massive retreat from the nation's commitment to improving the lives of blind and other severely handicapped people. Whether this was done by design or inadvertance, the result is the same.

Block Grant Proposals

Mr. Chairman, the several block grant programs proposed by the Administration would, if enacted into law, turn to shambles what has become a substantial system of service delivery to blind people. These would not only reduce the level of Federal financial assistance by 20 to 25 percent overall, but also would permit the complete elimination of programs benefiting blind and visually handicapped people. The theory of the block grant is to give States total latitude, limited only by the broad constraint to adhere to the general program purposes identified in the law. This means that any given State could reduce drastically or abolish vocational rehabilitation services for the blind for example, and provide the funds previously earmarked for those services to child welfare and day care programs.

Experience with the social services program under title XX of the Social Security Act has demonstrated that blind and other severely handicapped individuals and their organizations, particularly in the case of low incidence disability groups, are not equipped to compete successfully for scarce resources at the State and local level. Other, more powerful, vocal, and organized interests have been able to garner control of the bulk of these funds to benefit their particular programs.

We are concerned to the point of near certainty, that, with the major program consolidations envisioned in the proposed block grants, increasing numbers of vulnerable and needy people will expend their energies and attention in fighting with other groups of vulnerable and needy people. Because of the numbers, organization and resources of other interests, blind and other severely disabled people will suffer grievous reductions in services. We therefore urge most earnestly that this Committee recommend appropriations for fiscal year 1982 that reflect existing law, and a continued commitment of support for programs that are of vital importance to the independence and well-being of millions of our citizens.

Recommendations for FY 1982 Appropriations

Rehabilitation Services. The State formula grant program and all discretionary authorities administered by the Rehabilitation Services Administration (RSA) are proposed to be consolidated into a social services block grant in FY 1982. The total amount of social services funds requested is only $3.8 billion, compared with $5.0 billion funded in FY 1981. The continuing resolution for FY 1981 (PL 96-536) provided a total of $932 million for RSA programs, of which $854 million is for state formula grants and innovation and expansion activity. (The 1981 entitlement level for the formula grants is $948 million, including maintenance of effort requirements.)

The Senate Labor and Human Resources Committee recommended to the Senate Budget Committee a total appropriation for rehabilitation services and handicapped research for FY 1982 of $1,050 million, or $82 million above the FY 1981 continuation level. Although this amount is not adequate to maintain the current service level, in the interest of restricting federal expenditures AAWB and NCSAB endorse appropriations at the $1,050 million level.

In making this recommendation we wish to identify with greater particularity the program areas we believe should be emphasized.

The Helen Keller Center for Deaf-Blind Youths and Adults is the national training center for a group of very severely multiple handicapped individuals who are referred to the center from across the nation. Several satellite offices linked to the National Center provide professional training and services to deaf-blind clients. No state has the resources to provide the kind of expensive, specialized services needed by these people. The rubella epidemic of the early 1960s resulted in the addition of at least 5,000 deaf-blind babies to the population. Those children are now at or approaching adulthood. The nation must be prepared to meet their needs for development, training, independence, and even employment. The alternative is wasted lives. To assist the National Center to address the service needs of the deaf-blind rubella population, $4.0 million in federal appropriations is required.

Discretionary service grants and contracts. We urge the Committee to retain separate line item funding authority and appropriations for several important programs administered by RSA. Each of these provides substantial direct benefits to blind and visually handicapped persons. Under the general classification of service projects, special projects are the "cutting edge" of the rehabilitation program. Funds are used for innovative demonstrations of new kinds of service delivery, particularly for groups who are underserved by the rehabilitation system. Several important projects for blind, deaf-blind, and multiple handicapped persons have emerged, the results of which can be applied to the general population of clients served through the national blindness system. Client assistance projects, which are now located at 30 sites across the country, aid disabled vocational rehabilitation clients in cutting red tape, asserting their rights, and obtaining needed services. Funding should continue at $3.5 million. Projects With Industry is a highly cost-effective program in which private companies cooperate with rehabilitation facilities, State agencies for the blind and other rehabilitation agencies, and voluntary organizations in training and placing in competitive employment several thousand handicapped workers each year. The average cost per placement is $1,000. More than 2,000 corporations throughout the nation are participating in this program. Its proven performance and its potential justify substantially greater appropriations than have been provided in the past. We strongly recommend funding at a level of at least $10 million.

Facilities improvement grants have not been funded in the last two years. As a result upgrading and improvement of rehabilitation facilities has been critically inadequate. This program does not support construction, but rather improvements in operational services to blind and other handicapped clients. Facilities are an integral part of the rehabilitation system, but at a time when the need for them is increasing, relatively less attention is given to their improvement. The grant program for this purpose should be reinstituted in FY 1982 at a level of $7.5 million. In addition, the technical assistance program, which provides management and administrative aid to workshops and other facilities should be funded at $300,000.

Independent living, a program instituted in 1979, has just begun to demonstrate its effectiveness in bringing personal, social and financial independence to very severely disabled persons. The potential for this program is most promising. It frees family members for economically productive work, prepares severely disabled people for vocational rehabilitation and employment, and helps prevent institutionalization. Several projects for blind persons have been approved under Part B of Title VII of the Rehabilitation Act. Funding for Part C, which is specifically for independent living services for older blind persons, is triggered by formula grant funding under Part A. Since appropriations have not been enacted for Part A, the focus or older blind services in Title VII has not been realized. We recommend funding for independent living at a level that would permit the Part C setaside to operate, or alternatively, language in the appropriation bill and committee report that would protect the funding of independent living services for blind persons under Part B. This level should be at least $30 million.

Training is necessary to maintain the level of professional competence in a broad range of rehabilitation professions, including that for counselors, including counselors for the blind, facilities administration, and others, including orientation and mobility training and rehabilitation teaching for the blind. The current appropriation level should be restored to that of previous years: $28.5 million.

Research. Funding for programs under the National Institute of Handicapped Research should be adequate to at least sustain the current effort in research and engineering, including the maintenance of one Research and Training Center in the field of blindness. Greater emphasis is needed to insure the utilization of research and engineering developments by the service delivery system. More attention is needed to support projects which are perceived by commercial researchers, developers and manufacturers as high risk, low return endeavors but which in reality would have a high probability of widespread use among the disabled population. Aids and devices for blind and visually handicapped people may be among these. We therefore recommend funding of the Institute at a level of at least $35 million.

Education for the Handicapped. Formula grants to State education agencies and local education agencies as well as discretionary project funds, are proposed to be consolidated into two block grants and reduced by 25%. Since other, more education-oriented organizations are making recommendations in these areas, we are limiting our comment in this statement to an expression of support for a continuation of these programs without reduction.

Developmental Disabilities. Under the new functional definition of developmental disabilities, blind and visually handicapped children are included in the DD population. The State formula and protection and advocacy system grants, as with RSA programs, would be part of the consolidated Health and Human Services block grant for social services. The University Affiliated Program and special project grants would be folded into the social services discretionary program. There are valid, important reasons for continuing the Developmental Disabilities program as a distinct service. We support that continuation.

Conclusion

The two organizations submitting this statement are not unmindful of the great national need to reduce inflation and put the nation's economy on a sounder footing. Part of the solution to these problems lies in a containment of expenditures by the federal government. We join with the Congress, the Administration and the Nation's people in the hope that these problems can be solved; for blind people -- as all citizens -- are hurt by inflation, low productivity, and a sluggish economy.

No one objects to the goal; the disagreement arises in considering the means of accomplishing it. Blind and visually handicapped people, and all of America's millions of disabled citizens, are among the most vulnerable and needy in the country. Services designed to meet their needs have not grown in recent years; in fact, in real terms there has been a decline in funding over the last decade.

One of the great national benefits of service programs for blind people is their cost effectiveness. Millions of blind and otherwise disabled persons have become employed and have learned to live independently as a result of their participation in vocational rehabilitation, independent living, and other specialized programs. They have become taxpayers rather than recipients of tax dollars. Far more dollars are returned to governments and the economy as a result of these programs than are expended. Studies indicate that an economic benefit of at least ten dollars, and perhaps as much as $35 or more, is realized by rehabilitation clients and various levels of government for every dollar used for rehabilitation. Few, if any, federal programs have as great a return for the dollars spent. Put another way, unlike many government expenditures, the more funds expended for these programs, the greater the return. Such programs are truly anti-inflationary and should be ardently supported by the Congress and by the Administration.

We urge, therefore, that funds for the programs we have discussed be increased, not reduced, in accordance with our recommendations.

RECAPITULATION: RECOMMENDED APPROPRIATIONS FOR FY 1982

Rehabilitation Services	FY 1981 Continuing Resolution	FY 1982 Administration Budget	FY 1982 AAWB/NCSAB Recommendation
Formula grants to States	854	----	$910
Service projects	28.8	----	35.0
Special projects	(15.5)	----	(17.2)
Evaluation	(2.0)	----	(2.0)
Client Assistance	(3.5)	----	(3.5)
Comprehensive Rehab Centers	(2.0)	----	(2.0)
Projects With Industry	(5.5)	----	(10.0)
Technical Assistance	(.250)	----	(.3)
Facilities Improvement Grants	0	----	7.5
Helen Keller Center	2.5	----	4.0
Independent Living	18	----	30.0
Part A			(10.5)
Part B	(18)	----	(18.0)
Part C			(1.5)
Training	25.5	----	28.5
TOTAL Rehabilitation Services	$932	----	$1,015.0
Handicapped Research	$35	----	$35.0
GRAND TOTALS:	$967.6	----	$1,050.0

STATEMENT OF ROGER P. KINGSLEY, PH. D., DIRECTOR, CONGRESSIONAL RELATIONS DIVISION, AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

The American Speech-Language-Hearing Association (ASHA) is pleased to submit its views and recommendations on appropriations for programs under the jurisdiction of the Office of Special Education and Rehabilitative Services in the U. S. Department of Education. Physically and mentally handicapped persons comprise a sizeable portion of the nation's total population - somewhere between 25 and 35 million people. Along with providing appropriate educational opportunities to handicapped individuals, the most important activity in assuring that they will have maximum opportunity to fulfill their potential is to provide appropriate rehabilitation services.

The American Speech-Language-Hearing Association is a scientific and professional society consisting of over 35,000 speech-language pathologists and audiologists. These health and education professionals are concerned with the systems, functions, and processes of normal and abnormal human communication. ASHA Members are qualified to provide services in hospitals, speech and hearing clinics, outpatient rehabilitation centers (such as those run by the National Easter Seal Society and the United Cerebral Palsy Association), skilled nursing facilities, home health agencies, Head Start Programs, Veterans Administration and Department of Defense hospitals, public and private schools, and private practice. Approximately 45 percent of all ASHA Members work in a school setting.

ASHA sets and enforces a three-tiered standards program which is designed to assure high quality educational programs, competent clinical practices, and recognition of qualified professionals. Through the Council on Professional Standards, higher education programs are accredited under procedures recognized and approved by the Department of Education. Clinic programs are likewise evaluated and accredited by a Professional Services Board. In order to qualify for ASHA's Certificate of Clinical Competence (CCC), individuals must have successfully completed strict educational and training requirements. The CCC is awarded to individuals who a) complete a graduate course of study leading to a Master's or Doctoral degree in speech-language pathology, audiology, or speech and hearing science; b) complete 300 hours of a supervised clinical internship; c) pass a national examination administered by the Educational Testing Service; and d) subscribe to ASHA's Code of Ethics. The CCC is recognized by the Medicare and Medicaid programs as evidence of proficiency in dealing with speech, language and hearing disorders.

Recommendations for FY 1981 Funding: Office of Special Education and Rehabilitation Services Administration

The Office of Special Education (OSE) is charged with the responsibility of providing guidance and organization for state and local education agencies in carrying out Congressional mandates for a free and appropriate education for all handicapped school children in the nation. OSE has overseen remarkable progress in moving toward this goal during the past decade and in particular since implementation of the Education for All Handicapped Children Act (PL 94-142) began in 1977.

The Rehabilitation Services Administration has a central responsibility in implementing the Rehabilitation Act of 1973 (PL 93-112) and the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978 (PL 95-602). By providing direction and coordination for state vocational rehabilitation programs and by supporting rehabilitation services and training of professionals, RSA performs a central role in helping the handicapped gain the capacity to enter or reenter the workforce and to realize self-sufficiency to the mmaximum extent possible. Both RSA and OSE oversee programs that are vital to the full development of millions of people. The services which they fund cannot be cut or delayed without serious repercussions to both individuals and society.

ASHA would like to submit the following recommendations of federal appropriations for these two agencies.

Office of Special Education

Basic State Grant Program (Part B)

Continuing Resolution for FY 1981: $922 million

Administration's Revised FY 1981 Budget: $691.5 million

Administration's Recommendation for FY 1982 (advance appropriation for fiscal 1983): included in proposed local education block grant

ASHA Recommendation for FY 1982: $1.14 billion

Preschool Incentive Grant Program (Part B, Section 619)

Continuing Resolution for FY 1981: $25 million

Administration's Revised FY 1981 Budget: $18.75 million

Administration's Recommendation for FY 1982 (advance appropriation for fiscal 1983): included in proposed local education block grant

ASHA Recommendation for FY 1982: $30 million

Special Education Personnel Development (Part D)

Continuing Resolution for FY 1981: $58 million

Administration's Revised FY 1981 Budget: $43.5 million

Administration's Recommendation for FY 1982 (advance appropriation for fiscal 1983): included in proposed state education block grant

ASHA Recommendation for FY 1982: $63.8 million

Rehabilitation Services Administration

Basic State Grants

Continuing Resolution for FY 1981: $854.25 million

Administration's Revised FY 1981 Budget: $854.25 million

Administration's Recommendation for FY 1982: included in proposed health services block grant

ASHA Recommendations for FY 1982: $972 million

Rehabilitation Training

Continuing Resolution for FY 1981: $25.5 million

Administration's Revised FY 1981 Budget: $20.4 million

Administration's Recommendation for FY 1982: included in proposed health services block grant

ASHA Recommendation for FY 1982: $45 million

Education of Handicapped Children

Implementation of the Education for All Handicapped Children Act (PL 94-142) has been a paramount national achievement in improving the lives and life-long potential of thousands of children in the school age population. Over four million children are receiving special education and related services under programs supported by PL 94-142 and PL 89-313, and almost every state has shown impressive increases in the number of children served. During the three years since the implementation of PL 94-142 began, nearly

328,000 additional handicapped children have been identified[1] and given the attention and assistance they need in order to fulfill their physical, intellectual, social, and emotional capacity for growth. In this same time period the proportion of children receiving services supported by the Act increased from 8.2 percent to 9.5 percent of the total public school enrollment. This increase is particularly impressive when one considers that the overall public school population has declined by 6.2 percent since 1977.[2]

Public Law 94-142 also represents an achievement in federal-state relations. More than half of the states are now serving at least 9.66 percent of their students under federally authorized programs for education of the handicapped.[3] Currently, all but one state is participating in the PL 94-142 program. An increasing number of states are working out agreements between education agencies and other public agencies in order to more completely and effectively serve the special needs of handicapped children. The federal role in the education of handicapped children was never intended to substitute for the efforts of state and local education agencies. PL 94-142 was enacted by Congress in recognition of the need for a national policy which reflected existing court decisions and state laws guaranteeing children a free and appropriate public education. Through the Office of Special Education (OSE), the federal role has been one of assisting state and local authorities throughout the country in pursuit of this goal. The Office has served as a catalyst in promoting the effective use of local and state resources in developing annual plans, identifying unserved children, and assuring quality instruction and services. OSE's compliance activities have been based on a positive, non-interference, and non-adversarial approach designed to help states develop and use the resources needed to comply with the mandate of the law.[4]

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[1] Office of Special Education, U. S. Department of Education, Second Annual Report to Congress on the Implementation of Public Law 94-142: The Education for All Handicapped Children Act (1980), p. 18.

[2] Ibid.

[3] Ibid., pp. 22-24.

[4] Edwin W. Martin, Assistant Secretary for Special Education and Rehabilitative Services, written reply to questions submitted by Senate Subcommittee on the Handicapped, in Oversight on Education for All Handicapped Children Act, Part 2 (September 26, 1980), p. 429.

State Grant Program (Education of the Handicapped Act, Part B)

Because of the mandate, which requires that a free and appropriate public education be made available to all handicapped children, states must be in compliance regardless of whether or not full authorized funding is being provided. The State Grant Program provides federal financial assistance based on the number of handicapped children ages 3 through 21 who are counted as being served. Since the Act prohibits the use of federal funds to supplant state or local funds, such assistance is directed at covering the excess costs of special education and related services already being provided. Congress wrote into the Act provisions for an escalation in federal assistance from five percent of the national per pupil expenditure in FY 1978 to 40 percent in FY 1982. The actual federal contribution, however, has remained far below the authorized level. For the states to meet the challenge of education for all handicapped children under these circumstances, state and local education agencies must come up with additional expenditures for personnel, facilities, materials and equipment. However, the Congressional Budget Office has reported that educational expenditures will exceed state and local revenues through the remainder of the decade.[5]

The $922 million appropriated for Part B State Grants in the current fiscal year represented a freezing of the federal contribution at slightly less than 12 percent. With inflation taken into account along with the increase in the number of handicapped children being served, this appropriation already amounts to an erosion of federal help to the states relative to the previous fiscal year. The Administration's proposal to rescind $230.5 million, if agreed to by Congress, would bring the federal contribution down to a level of 8.5 percent and would be a serious setback in the capacity of SEAs and LEAs to provide for the special education and related service needs of their student populations. The Senate Labor and Human Resources Committee, in a bipartisan and nearly unanimous vote, recommended a modest increase to $1.14 billion for FY 1982 funding of the State Grant Program. We believe that this is a realistic recommendation in light of both inflationary pressures and the clear public support that has been voiced for continuing the forward momentum of PL 94-142.

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[5] Congressional Budget Office, Elementary, Secondary, and Vocational Education: An Examination of Alternative Federal Roles (1977).

Preschool Incentive Grant Program

The Preschool Incentive Grant Program was included by Congress in the Education for All Handicapped Children Act in order to encourage the states to provide necessary services to the youngest school age population. States are required to provide these services to children ages 3 through 5 unless there exists a state law or court order that bars such a requirement. Currently, 16 states mandate services for children in the 3-5 age range and another 22 states require services at age 4 or 5. On the whole, the states are serving only 2.6 percent of the preschool population[6] - a dismal record considering the ample evidence that early recognition and treatment of handicapping conditions can significantly reduce the number and severity of disabilities in later years.

According to OSE, the Preschool Incentive Grant Program served about 232,000 children in the 1979-80 school year. This represented an increase of nearly 17,000 children from the previous school year.[7] Since the funding allocated for the program remained at $25 million (the full authorized level in FY 1981 is $66 million), the per child allotment has necessarily declined. Slashing 25 percent from the current allocation as the Administration has recommended would be a serious setback for this worthwhile program. The $30 million recommended for Preschool Incentive Grants by the Committee on Labor and Human Reources is the minimum funding level that Congress should consider.

Special Education Personnel Development

Without properly trained, accessible, and sufficient personnel, it is difficult to envision the successful implementation of the primary goals of PL 94-142 - attainment of a free and appropriate public education for all handicapped children. There must be a continuing expansion of programs to train special education teachers and related service professionals such as audiologists, speech-language pathologists, occupational therapists, physical therapists, guidance counselors, and school psychologists. Also important is the "inservice training" of all educational personnel, including regular classroom teachers and school administrators, who interact with handicapped children. According to data reported by OSE, the demand for specific disability specialists continues to exceed the supply. In its recent Report to Congress, OSE demonstrated that there was a nationwide need for 39,700 speech teachers/speech-language pathologists during the 1978-79 school year, but that only 33,100 were actually available.[8] The gap between available and needed speech professionals cannot be filled by reducing funds for special education personnel development.

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[6] Office of Special Education, Second Annual Report to Congress, pp. 3, 24-27.

[7] Ibid., p. 25.

The situation is even more critical with regard to services for hearing-impaired children. ASHA estimates that of every 10,000 school age children 57.5 can be expected to suffer from some kind of hearing impairment. The audiologist plays a dual role in the public schools. He or she must be involved with the screening of all children in order to identify those with hearing losses and must provide necessary services to those who have been identified as hearing impaired.

An ASHA survey found an average of only 1.41 audiologists per school district in 1978-1979, an actual decrease from the number in the previous school year. The availability of audiologists varies greatly among the states, but in no state is the number sufficient to meet the hearing conservation and audiologic rehabilitation needs of the student population. In Georgia the audiologist-pupil ratio is 1:20,000. In Ohio and South Dakota the ratio is 1:10,000. In Kansas the ratio is 1:7,000.[9] In the area of hearing services, the appropriate staff-pupil ratio depends to a large degree on the range of services that are to be provided. A lower ratio is appropriate when audiologists provide comprehensive assessment and rehabilitative services and not just identification and evaluation services. This Association, along with the Conference of Executives of American Schools for the Deaf, has determined that when audiologists are involved in providing special instructional and habilitative services in an educational setting, there should be a minimum of one audiologist for every 75 hearing impaired children.[10] However, if a school district desires adequate screening of its students as part of a preventive health program, a considerably larger number of audiologists is needed to serve both the general and the hearing impaired student populations.

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[8] Ibid., pp. 200, 207.

[9] School Services Program, American Speech-Language-Hearing Association, "Language, Speech, and Hearing Programs in the Schools," (1978).

The current allocation of $58 million for special education personnel development is inadequate to ensure the availability of sufficient numbers of qualified personnel. The proposed rescission of $14.5 million would lead to worsening shortages in the pool of professionals available to educate and rehabilitate handicapped school children. The authorized level of funding for this section of the Education of the Handicapped Act is $90 million in FY 1981 and $95 million in FY 1982. A ten percent increase over the current appropriation would bring funding next year to $63.8 million, an amount that would at best keep the present personnel shortage from becoming worse.

Vocational Rehabilitation of Handicapped Individuals

The Rehabilitation Services Administration has primary responsibility for overseeing programs which aim to rehabilitate handicapped persons so that they become employable and self-sufficient. For the past 60 years, the federal Rehabilitation Services program has been the focal point of the nation's commitment to assist the handicapped in their quest for productive and fulfilling lives.

Since 1921, the federal-state partnership in vocational rehabilitation has provided services to over 21 million persons and has rehabilitated more than six million of them. During the past year alone, the program provided services to 1,353,476 handicapped individuals and successfully rehabilitated 252,666 people into gainful employment. RSA has reported significant progress being made by the states in developing innovative programs in long-term training, independent living, mental health centers, and outpatient rehabilitation. There have also been notable achievements in rehabilitating specific disability populations, such as the deaf and hearing impaired, despite meager financial and manpower resources. Despite these achievements, the vast majority of handicapped adults remain without the rehabilitation services they need. The total number of Americans with a complete work disability is over seven million. Over one-half million are prevented from working as a result of speech, language, or hearing disorders. Among the estimated 16 1/2 million people with a partial work disability are one million who suffer from communicative impairments.[11]

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[10] American Speech-Language-Hearing Association and Conference of Executives of American Schools for the Deaf, "Guidelines for Audiology Programs in Educational Settings for Hearing Impaired Children," Asha, Vol. 18, No. 5 (May 1976): 291-294.

With respect to overall health care delivery, it is clear that there must be an increased emphasis on preventive and diagnostic services. In this regard, we concur with statements made by the Secretary of Health and Human Services indicating this Administration's commitment to prevention in the health field. Such an approach is obviously essential if we are to effectively reduce the number of individuals who are dependent on rehabilitative services. Rehabilitation services are preventive in an important sense because they prevent the loss of productivity and the wasting of human potential. Whether these services are viewed in terms of prevention or treatment, one principle must remain paramount: This nation has a commitment to helping its population of handicapped children, adults, and senior citizens. Because of congenital impairments, accidents, and severe illnesses, there are hundreds of thousands of new individuals each year who require rehabilitative services. Fiscal exigencies must not be made a rationale for turning away from these persons. Their fundamental rights in areas like education, employment, housing, and transportation will not be achieved by accident but must continue to be guaranteed through government's traditional commitment to protect the truly needy.

The Rehabilitation Services program has, with a relatively modest public investment, paid enormous dividends by making it possible for thousands of persons each year to become vocationally productive, and thereby contributing to the nation's economic well-being rather than adding to the public burden of unemployment, welfare, and costly institutional care. The earning potential for rehabilitated persons is many times the cost of their rehabilitation. State governments have actually overmatched the federal rehabilitation services grants. However, the real dollar decline in 1981 funding and the substantial loss of federal support in succeeding years is not likely to be made up by the states. The impact of the proposed reductions in rehabilitation funding will not only be felt by thousands of individuals who will be deprived of services but also by the general economy which will shoulder the consequent costs in terms of state and federal unemployment compensation, welfare, health care, institutionalization, and lost revenues.

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[11] Bureau of Census, U.S. Department of Commerce, Survey of Income and Education (1976).

Vocational Rehabilitation State Grant Program

The Rehabilitation State Grant Program should be funded at the authorized level of $972 million for fiscal year 1982. The Program has historically been recognized by both the House and the Senate as a legal entitlement, and the mandate of the Rehabilitation Act is for Congress to allocate the full authorized amount to the states.[12]

When the size and needs of the handicapped adult community are considered, full funding does not appear to be an immodest request. That it does not go nearly far enough becomes obvious when one looks at the last full funding year - fiscal year 1979 - in which only one in 20 eligible handicapped persons was served. Moreover, because the 1978 Rehabilitation Act amendments require priority funding for the most severely disabled, it has become increasingly difficult for state rehabilitation agencies to provide services for many handicapped persons who could benefit from them. It is generally recognized that the cost of rehabilitating a severely disabled person is two and one-half times as great as the cost of rehabilitating a non-severely handicapped person. Combined with inflation that has steadily outpaced increases in rehabilitation funding, the states are able to serve fewer people with the inevitable result that fewer are able to make the transition from being disabled and unproductive to a vocationally productive status. Any freeze or reduction in federal funding will lead to a further decline in the capacity of the states to rehabilitate their disabled populations. An indiscriminate budget cutting strategy which has such consequences is obviously not cost effective and, hence, is self-defeating.

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[12] cf. Testimony of Members of Congress, Labor HEW Subcommittee of the Committee on Appropriations, Departments of Labor, Health, Education, and Welfare and Related Agencies Appropriations for 1981, Part 10, pp. 344-60.

Rehabilitation Personnel Training

Perhaps most ominous to the future effectiveness of rehabilitation services is the Administration's request for a recission of $5.1 million from FY 1981 appropriations for the training of rehabilitation personnel. The existing amount of $25.5 million already represents a $3 million reduction from the previous fiscal year and is far below the amount authorized by Congress.

During the last ten years there has been a steep decline in funding available for training in various rehabilitation disciplines. In 1969, speech-language pathology and audiology programs were funded at $3.6 million. In the past budget year, RSA funding for these programs fell below $1 million. While it is true that these and other independent health professions grew rapidly during the 1960s and 1970s, further expansion is still needed if these professions are to adequately serve their constituents.

In order for rehabilitation services to be most beneficial to handicapped persons, it is essential that they be provided by appropriately trained professionals. The decline in funding in this area will probably lead to a reduction in both the quantity and quality of rehabilitation professionals. Congress authorized $45 million in FY 1981 and $55 million in FY 1982 for this program, and we believe that these figures are realistic estimates of the amounts that will be needed to maintain current programs and to improve rehabilitation in underserved areas.

Conclusion

This Association does not contend that the federal education of the handicapped and rehabilitation services programs are perfect nor that areas of inefficiency and waste might not be found that would allow for cost reductions. We do contend that these are vitally important programs in terms of the physical, educational, social and economic well being of millions of handicapped persons. These are public education and health programs which have been built upon many years of congressional planning, administrative implementation, and the active commitment of numerous concerned individuals and groups. Programs on which so many persons have come to depend for assistance in acquiring the opportunities for reaching their educational and vocational potential should not be the targets of precipitous budget cutting strategies. Any legislative action that would have the effect of reducing the size and scope or otherwise modifying these programs should await consideration by the appropriate committees of Congress and should allow for full and open public hearings. For these reasons we strongly oppose the recission requests that have been made by the Administration in FY 1981 appropriations and the FY 1982 budget recommendations for programs under the jurisdiction of the Office of Special Education and Rehabilitative Services.

We have heard that these budget cuts are necessary to help bring about economic recovery by controlling inflation, reducing unemployment, and reindustrializing America. We share in these economic concerns and goals for our nation. Where we respectfully disagree with proponents of these budget cuts is in the solution. Slashing funds for PL 94-142 and rehabilitation services will result in very minor savings for the federal budget in its entirety, but are likely to have damaging, and in many cases, lasting effects on millions of handicapped children and adults. These are individuals who, without the special services these programs provide, will have less chance of becoming well-educated and productive citizens. Rather than contributing to society and national economic growth, many will be unemployed or underemployed, welfare-dependent, and dependent on care in costly institutional settings. In this way, short-term budget cuts are likely to have serious long-term consequences for the handicapped and the non-handicapped alike.

STATEMENT OF COMMITTEE OF URBAN PROGRAM UNIVERSITIES

The Committee of Urban Program Universities consists of 34 urban universities, public and private, located in urban areas from Boston to Los Angeles, from Minneapolis to Atlanta, from Houston to Norfolk. The organization was created for the express purpose of seeking enactment and funding of Title XI of the Higher Education Act--the Urban Grant University Program. On October 3, 1980, Title XI became law. This is our initial statement on the desirability of funding the title.

Title XI is one of relatively few new initiatives in the Higher Education Act since the 1972 amendments became law. Enacted in 1980, this is the first year it is eligible for funding. The 1980 authorization language permits funding for FY 1981 in an amount up to $15 million, and for FY 1982, up to $25 million. Nothing was requested or appropriated for FY 1981, and, indeed, nothing could have been requested or appropriated because of the funding schedules involved. The Budget of the United States as submitted by President Carter calls for an appropriation of $1.5 million for FY 1982. This amount, according to the Budget analysis, would fund from six to ten Title XI programs, and we believe that to be a reasonable estimate of how far those funds would go.

We would, given the best of all possible worlds and the most prosperous of all possible years, prefer to request modest supplemental funding (but in excess of $1.5 million) for FY 1981, and a major step toward full funding for FY 1982.

We emphasize that Title XI is not an entitlement program, nor is it a formula grant program. It was written, and consciously and intentionally so, to leave the hands of the Congress untied in deciding upon annual appropriations levels. In a year like this one, when all programs are under fire, we do not expect Title XI to escape unscathed, or fully funded.

While we believe, without exaggeration, that the Urban Grant Act could indeed utilize $15 million effectively and productively in this initial year of operation, we also recognize, without despair, that the Congress is not likely to appropriate anything like that.

We do believe that $5 million is a responsible request. This amount could be utilized to fund 20 to 30 projects distributed throughout the nation to give this concept a fair opportunity to demonstrate its utility to our cities and our nation in these times of austerity.

Put simply, Title XI would provide small grants to universities located in and already committed to serving urban areas, to enable those universities to assist those local governments with applied research and services on problems which the local governments consider as high priority. The Act provides no formula for distribution of the grants, no shopping list of federally-determined problems, and neither the need for nor the justification of the creation of any massive Federal bureaucracy for its administration.

We in the Committee of Urban Program Universities, who shared the parentage of Title XI with members of your Subcommittee and other Members of the Congress, take some pride in the fact that this legislation, and the arguments for its passage, anticipated some of the soundest concepts which are currently shared by the Reagan Administration and its friends and critics alike in the Congress.

Title XI has always emphasized the concept that local governments can do a good deal more not only to meet local problems, but to determine what those problems are, than can anyone in Washington. The legislative history of Title XI is replete with the idea that the Department of Education's role under the title is not to decide what the problems of the cities are. The cities are to determine their problems, the universities are to decide what their own areas of competence are, and where the two can agree on an agenda, and there only, applications for Federal support may be submitted.

The role of the Department of Education is limited to deciding on the basis of the demonstrated working relationship between town and gown, which projects show the greatest promise and should be funded.

Title XI's proponents, in the Congress and in the urban university community, agreed from the start that the universities should not mount or pretend to mount a massive assault on the problems of cities, basing our hopes for success on the sheer brilliance of our research and service capabilities. Recognizing, rather, that there are limits to what government--Federal or local, and the educational sector, public or private--can do, we have eschewed the use of the phrase "solve problems", and have said frankly that we felt Title XI could help some cities find data helping them respond to some kinds of questions. There are big problems confronting the cities which can best be met without the help of the local university. There are situations in which the local university is the problem. But there are also areas where a local government's needs for information, for analysis, for forecasting, for background research, can uniquely be met, at minimal cost to the cities, by the faculty and facilities and students of the urban-oriented university. Title XI provides a mechanism for initial support for that kind of relationship, where the city and the university want it to exist. In the long run, Title XI should result in far more city-university cooperative undertakings than are federally supported. But in the beginning, this Title proposes to invest in showing how this kind of relationship can grow.

In 1980, Title XI attracted bi-partisan support from both Houses, both sides of the aisle, every part of the ideological spectrum, the entire higher education community, and from an impressive list of mayors of cities large and small. Meeting with almost no enunciated opposition, the new Title was born with high hopes.

While the events of the past several months have sobered the outlook, they have not dimmed those hopes. We still believe that the Urban Grant concept can work and work effectively in providing some answers to some urban questions.

We have taken considerable encouragement from the President's remarks before the National League of Cities announcing his continued support for the Urban Development Action Grant program. UDAG, which helps create city-private sector linkages, was defended by the President on the grounds that it eliminated "wasteful federal administrative overhead and gives local governments more flexibility and control". The same terms can be used to state the core concept of Title XI, which will help create city-university linkages without excessive Federal control.

We believe that this legislation is fully in accord with the temper of the times in terms of the trend toward simplification and decentralization. We believe that it can be a model program in terms of a minimum of Federal interference and decision-making. We believe that it can provide a handsome return on a small investment.

But while our organization is directly concerned only with Title XI and this statement deals only with the funding of that Title, we cannot ignore the damage that would be done to our members, their students, and the remainder of the higher education community by the cuts the President's Budget has proposed in Title IV.

This organization will not join with those, rightly criticized by the President, who profess support for the President's entire program except where it happens to impinge on their own narrow parochial interests. In fairness--no, in simple justice--to the higher education community and to the entire society of which higher education is a vital underpinning, we have to admit flatly that the President's proposals for slashing federal student assistance would do far more harm to higher education, specifically including our own members--and to society as a whole, than full funding of Title XI would do it good.

We urge funding of Title XI at the levels suggested above. But we also join with the rest of higher education in urging a continued Federal commitment to student financial assistance.

We would be going contrary to our basic belief that the identity of the problems and the nature of the responses should be decided locally if we tried, in this testimony to set forth in detail what kinds of things could be done under Title XI. But we can rise above principle enough to outline some of the sorts of things that our member institutions have been doing, which are analagous to what can be done by them and by other urban universities if Urban Grant receives an appropriation.

The University of Cincinnati working closely with City Hall has developed "Project Matchmaker", under which a person has been hired full-time whose function is to "float" between City Hall and the University to find out what is needed by the former and what can be done by the latter. Matchmaker was actually first proposed by the then-City Manager, William V. Donaldson, and put into effect when University President Henry Winkler was able to locate some university funding to begin the program. The Cincinnati "Matchmaker" not only locates urban problems, but performs the basic task of translating the respective jargons of government and the campus into a mutually understandable language. In a 1979 article in Ohio Cities and Villages, a publication of the Ohio Municipal League, projects developed through "Matchmaker" were described. These included the provision of accounting assistance to enable the city engineering office to develop a cost-efficient billing process, and the provision of technical assistance to a long term study of the city's paratransit system. "Matchmaker" itself could be a fundable project under Title XI, as could either of these two examples of more specialized undertakings.

Georgia State University has conducted a research project on Neighborhood Abandonment to help establish the appropriate roles of government, business and neighborhood groups in dealing with this growing problem affecting many older cities. Georgia State has worked, too, with Atlanta area social service agencies training the personnel of such agencies to determine the cost effectiveness of money spent on social programs. Forty principals in the Atlanta public school system were trained in assisting their schools to implement a competency-performance appraisal system.

The University of Pittsburgh's Ethnic Heritage Studies Center is involved in the development of demographic materials affecting such areas as urban migration, community cohesion and viability, land use, etc.; the preservation of records of community organizations; the development of community historical projects including oral history project analysis and the preservation of community records, and in other ways.

The list could be added to, but your committee wisely told our committee to limit its presentation to a manageable size. And in any event, what is helpful to one city may be useless in another. The principle of Title XI is that each city has unique problems, each urban university has unique capabilities, and a catalyst will help to bring the two together.

We urge the funding of Title XI at $5 million to begin this exciting undertaking in helping the university be a better citizen and the city become an even better place to live.

This testimony has the specific endorsement of the National Association of State Universities and Land-Grant Colleges, the National Association of Independent Colleges and Universities, the American Association of State Colleges and Universities and the Association of Jesuit Colleges and Universities. In addition, the American Council on Education, speaking for the entire higher education community, has specifically endorsed appropriate initial funding for Title XI.

The members of the Committee of Urban Program Universities are:

University of Alabama at Birmingham--S. Richardson Hill, President

University of Cincinnati--Henry R. Winkler, President

Cleveland State University--Walter Waetjen, President

University of the District of Columbia--Lisle Carter, President

Georgetown University--Rev. Timothy S. Healy, S. J., President

Georgia State University--Edmund Hughes, Vice-President

University of Houston--Charles Bishop, President

University of Illinois, Chicago Circle--Donald Riddle, Chancellor

Los Angeles Consortium of Urban Universities:

    California State University, Dominguez Hills--Donald Gerth, President
    California State University, Long Beach--Stephen Horn, President
    California State University, Los Angeles--James Rosser, President
    California State University, Northridge--James Cleary, President

California State Polytechnic University, Pomona--Hugh LaBounty, President
University of Southern California--James Zumberge, President
University of Louisville--William F. Ekstrom, Acting President
University of Massachusetts/Boston--Robert Corrigan, Chancellor
University of Minnesota--C. Peter Magrath, President
University of Missouri, Kansas City--George Russell, Chancellor
University of Missouri, St. Louis--Arnold Grobman, Chancellor
University of Nebraska, Omaha--Del Weber, Chancellor
New Jersey Institute of Technology--Saul Fenster, President
City College of New York--Arthur Tiedemann, Acting President
City University of New York--Robert Kibbee, Chancellor
Northeastern University--Kenneth G. Ryder, President
Northeastern Illinois University--Ronald Williams, President
Old Dominion University--Alfred B. Rollins, Jr., President
University of Pittsburgh--Wesley Posvar, Chancellor
University of Rhode Island--Frank Newman, President
Rutgers University--James Young, Provost, Newark Campus
University of South Carolina, Spartanburg--Olin B. Sansbury, Jr., Chancellor
Temple University--Marvin Wachman, President
Texas Southern University--Leonard Spearman, President
Wayne State University--Thomas N. Bonner, President
University of Wisconsin, Milwaukee--Frank Horton, Chancellor

Board Members emeriti:

Dr. Werner A. Baum
Dr. Carlo L. Golino
Dr. James G. Miller

STATEMENT OF RICHARD H. BARNES, PRESIDENT, NATIONAL ASSOCIATION OF VETERANS PROGRAM ADMINISTRATORS

I appreciate the opportunity to present this written testimony to this distinguished committee to express the views of the National Association of Veterans Program Administrators (NAVPA) on the proposed rescission of the Veterans Cost of Instruction Payments Program (VCIP) as outlined in the Justifications of Appropriation Estimates for Committees on Appropriations, Fiscal Year 1981; Rescissions; Department of Education.

The National Association of Veterans Program Administrators is a non-profit organization, comprised of professional educators who administer veteran's programs on the campuses of 1,017 institutions of higher learning. Most of these programs are funded under the Veterans Cost of Instruction Payments Program (VCIP) which is administered by the Department of Education. The programs provide five legislatively mandated services: outreach, recruitment, counseling, special education, and maintenance of a full time Office of Veterans Affairs. These are the minimum services provided. The overwhelming majority provide services that far exceed the mandates of the legislation. Services being provided are accessible to all students at each institution who are eligible to receive Veterans Administration benefits. The number actually being served may be one and one-half times the number documented by VCIP program reports.

The decision to rescind the VCIP program by the Reagan Administration was based on incorrect and misleading information. We have been informed that the decision and rationale to rescind the VCIP program was completed by budget planners without consulting or requesting information from the Veterans Program Branch or reviewing any of the program documents or reports. I would like to present in this paper some information which I believe substantiates that the rationale for rescission is based on incorrect information and that the VCIP program should not be rescinded as it is providing the services to Vietnam Era Veterans as mandated by legislation and in a cost effective manner. I would now like to take the rationale for the proposed rescission as stated in the Rescission Document[1] and provide the reason we believe the information to be incorrect.

1. The Department of Education Rescission Document states: "...the number of eligible veterans had declined to 320,500. Projections indicate that eligible enrollment is likely to fall below 276,000 in 1981." This figure does not accurately depict the numbers of students served by this program. The 320,500 figure is not the number of veterans the program serves, but the Full-time Equivalent (FTE) number of veterans that is used for funding purposes. The VCIP program regulations, Title 45, Section 189.3, defines that only undergraduate, half-time enrolled or more, receiving benefits under Title 38 Veterans Administration Chapters 31 or 34 may be counted for the purpose of funding under this program. These figures, both for 1980 and projected for 1981, do not reflect the services provided to graduate student veterans, widows, orphans and dependents of disabled and deceased veterans, veterans who may be out of G.I. Bill entitlement, and many others including active duty using tuition assistance and those not eligible under this G.I. Bill. A survey completed by NAVPA[2] of the VCIP institutions shows that the numbers of students served by the program may exceed 500,000. The projected figures have not taken into account the

increase reported this year by many institutions over last years figures.[3] Nor did it take into account the figures released by the Veterans Administration in late 1979 that indicated as many as 4.5 million veterans still had entitlement remaining and were still eligible to use their benefits. The dramatic decrease in the numbers of veterans reported by this program in 1976 is a result of the 10 year delimiting date imposed on this G.I. Bill. In 1976, all veterans who were discharged prior to May 31, 1966, lost their eligibility for the G.I. Bill and although they may have stayed enrolled and used the services of the VCIP offices, they cannot be counted for the purpose of this program.

2. The rescission document further states: "...the award under VCIP is determined by the number of veterans enrolled, the decline in enrollment has resulted in smaller awards to the institutions." The statement is correct except that it does not take into account the supplemental money provided by the institution. A review of the Fiscal Operations Reports[4] of the program would show the actual amounts of money the offices operate with each year. The amount of money contributed in the last fiscal year by institutions towards the operation of the Office of Veterans Affairs was over $7,715,000.[5] Most of the supplemental money comes from the Veterans Administration Reporting Fee for these offices doing the certification of veterans as a part of their services. Also the awards have become smaller as a result of the decreased appropriations. The smaller appropriations have been based on the fact that $46 dollars per FTE Veteran each year is what the program needed. The fact is that the amount paid for each FTE veteran has been different each year and is determined by dividing the amount of money appropriated by the number of eligible veterans and arriving at a figure for each Catagory I FTE Veteran.[6] Appropriations cannot be determined by a preset FTE amount of money.

3. To continue, the rescission document states: "...result in a reduction in the quantity and quality of the services...". A review of the Program Operations Reports[7] of the VCIP program would provide information that would dispute this statement. Most of the programs and the services they

provide have remained constant even with fewer dollars and in many cases have improved as the coordinators time in the program increased and they make better use of their personnel and work-study students.

4. "..., institutions should be able to absorb the smaller number of veterans into their traditional counseling and service programs." For the most part, they cannot and not with such short notice. The Vietnam Era Veterans are not traditional students. This year their average age is over 32. The vast majority of services on college campuses are designed for students aged 18-22. Also many of the veterans are educationally disadvantaged and have been out of school for a long period or only have a GED. Most campus services are not geared towards these types of students but towards the traditional high school graduate who begins college the following fall semester. Many of the counselors are younger than the veterans, or were in college while they went to war, or have no experience that relates to the veterans problems. Most do not understand the problems of the veterans and lack the empathy they receive from the VCIP staff. Also, the certification process to the Veterans Administration has been incorporated into 90% of the VCIP offices.[8] This function must continue if the veterans attend the institution. Certification has become three times more complicated in the last five years with increased accountability. Without the expertise of the Veterans' Coordinators and the VCIP program, the problems with the certification process would increase dramatically. Many veterans will not be able to attend school because of delays or because of certification problems, which is the same as denying them their benefits. More importantly, the amount of overpayments to the government would increase again. This could cost the taxpayer and the government more time and money than the cost of the VCIP program. The proposed rescission of the VCIP program on June 30,1981, does not allow institutions a sufficient amount of time in which to assume the total financial obligations for the program. As a result of this, the majority of these programs will cease to function on June 30, 1981. To insure an orderly transition from federal funding to institutional funding, a provision not required of this program, requires a period of time longer than five months. Institutions cannot be expected to replace federal funds on such short notice and without any prior notification. The orderly

transition from federal to institutional funds should occur during the remaining years the program is authorized. During this period,the VCIP program needs to have a stable level of funding of not less than the $12 million level. This would allow the program to retain its professional people and for them to concentrate on accomplishing the mandates of the program effectively instead of spending time to keep the program alive.

5. "...Veterans Administration has eliminated their Veterans Representatives on Campuses" (VROC). The Veterans Administration phased out the VROC program but the major reason was not the decline in enrollment but because of budget cuts by the Carter Administration in the VA budget. The budget decision to phase out the VROC program continued because the institutions could now provide the services with the VCIP program, and also because the VROC program did not receive its full funding support as called for in its authorization. The Director of the Veterans Assistance Service in the Veterans Adminstration and program documents could correct this error.

We have attempted to provide other information for the major statements that are contained in the rescission document which may shed new light on the VCIP program. There are several other issues that should be addressed in this testimony relating to the VCIP program that provide further insight into this productive and cost effective program and the need for its continuance.

The VCIP program has never achieved full funding status since its inception in 1973,[9] and except for one supplemental funding period, the program operated at the $23 million funding level through 1978. In 1979, the funding was decreased to $19 million; in 1980 to $14.38 million, and was scheduled for $12.03 million in 1981. This is a decrease over a three year period of 49.4% of the program appropriations. This amount exceeds the Reagan Administration's requested budget cuts in federal program spending. VCIP has reached a level of minimum funding if we are to carry out this program effectively.

The new proposed regulations for VCIP[10] include input from this Association and from the VCIP institutions. These new measures were requested as money and time saving regulations for the program. Few other programs have requested a reduction in the maximum award of nearly 50%, from $135,000 to $75,000 and for an increase in the amount that must be used in the operation of the program, from 75% to 90%. While other programs request increased awards, VCIP institutions have seen the need, with decreasing appropriations, to maximize the awards of all participants in the program. The new regulations also streamline the administrative process of the program which could decrease the administrative costs within the Department. Also VCIP has a minimum of regulations and paperwork. There are three major reports required that take less than 4 total hours to complete. This includes the application. The regulations are concise and reduced to a mimimum, all of which fall within President Reagan's guidelines for programs.

The VCIP program is the only program of its kind directed towards Vietnam Era Veterans in Education and the only program outreaching to these veterans to assist them into education and to use their G.I. Bill. While the Veterans Administration has improved its outreach efforts, its direction thorugh the new "VET CENTERS" is towards psychological counseling of Vietnam Era Veterans for such problems as Delayed Stress. It must also be noted that although Veterans Administration Statistics indicate the rate of usage of the G.I. Bill is near 60%, that figure is not representative of the number of veterans who have completed training, rather, it is the number who started training. The VCIP program is assisting many of these veterans whose first experience was less than satisfying or who were not prepared for higher education.

In conclusion, the Veterans Cost of Instruction Payments Program is an efficient, cost effective program that is serving a population of Vietnam Era Veterans that still need assistance. The President stated in his budget speech and in his speech on Tuesday, February 24, when he presented the Medal Of Honor to a Vietnam Veteran, that the needy of the country would not suffer nor be picked out to carry an unfair burden of the budget cuts, and secondly, that the Vietnam Veterans have not received all that they should have received from their country. The Veterans Cost of Instruction Program is designed to assist these veterans who are in need of readjustment to compete with their peers in society. The National Association of Veterans Program Administrators is confident that the VCIP program is a part of that readjustment and commitment to the Vietnam Era Veteran. The program is one that should be reconsidered by both the Administration and the Congress,before the rescission process proceeds further, as an effective, efficient and very successful federal program that should be continued.

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1. Justifications of Appropriation Estimates for Committees on Appropriations, Fiscal Year 1981; Rescissions; Department of Education; Jan. 1981.

2. National Association of Veterans Program Administrators, Veterans Enrollment Survey (Unpublished), November 1980.

3. Veteran Student Enrollment Verification; Veterans Program Branch, Deapartment of Education, October 1980 & February 1981.

4. Fiscal Operation Report; Veterans Program Branch, Department of Education.

5. Ibid

6. Funding Summary Veterans' Cost of Instruction Payments Program (VCIP) Veterans Programs Branch, Department of Education

7. Program Operation Report; Veterans Programs Branch, Department of Education.

8. National Association of Veterans Program Administrators, Veterans Enrollment Survey (Unpublished), November 1980.
   NAVPA Model Office Committee, Veterans Program Self Review Sample, Fall 1980.

9. Funding Summary Veterans' Cost of Instruction Payments Program (VCIP) Veterans Programs Branch, Department of Education

10. Federal Register, Tuesday, December 30, 1980.

Statement of Ernest M. Spokes, Acting Dean, School of Mines & Metallurgy, University of Missouri

IN 1981 THE UNITED STATES IS FACED WITH HIGH INFLATION, A TIGHT ENERGY SITUATION, AND A NON-FUEL MINERALS PRODUCTION AND CONSUPTION PATTERN THAT COULD LEAD TO DISASTER IF FOREIGN SUPPLIES WERE TO BECOME UNAVAILABLE FOR ANY REASON. TO SOLVE THE PROBLEMS OF SUPPLY, IT IS ESSENTIAL THAT OUR MINERALS INDUSTRY HAVE AN ADEQUATE NUMBER OF SPECIALLY TRAINED ENGINEERS AND SCIENTISTS ENTERING THE JOB MARKET EACH YEAR.

THE GRADUATES AT ALL DEGREE LEVELS ARE IN DEMAND BY INDUSTRY AND GOVERNMENT. THE SCARCITY IS SO GREAT THAT IN MANY OF THE DISCIPLINES NEW COLLEGE GRADUATES COMMAND SALARIES THAT GENERALLY EQUAL AND FREQUENTLY EXCEED THOSE OF YOUNG PROFESSORS. BECAUSE OF THIS SITUATION, A VERY SMALL PROPORTION ENTER GRADUATE EDUCATION. THOSE WHO DO GENERALLY LIVE AT A SUBSTANDARD INCOME APPROXIMATING 25% OF THE SALARIES OF THEIR CLASSMATES WHO ENTER INDUSTRY AND MUST PAY THEIR EDUCATIONAL EXPENSES FROM THIS SMALL INCOME. EVIDENCE SUGGESTS THAT TO HAVE A STRONG GRADUATE PROGRAM, STIPENDS FOR STUDENTS

SHOULD EQUAL ONE-HALF OF THE AVERAGE SALARY OF A B.S. DEGREE GRADUATE ENTERING INDUSTRY.

AS A RESULT OF THIS SITUATION, WE FIND FEWER AMERICAN STUDENTS ENTERING GRADUATE PROGRAMS IN THE MINERAL DISCIPLINES. THEY ARE BEING REPLACED BY FOREIGN STUDENTS, PRIMARILY FROM ASIA, AFRICA, AND LATIN AMERICA. WHILE MANY OF THESE RETURN HOME TO PROVIDE LEADERSHIP IN THEIR INDUSTRIES AND UNIVERSITIES, OUR UNIVERSITIES ARE FACED WITH THE PROSPECT THAT WE WILL BE FORCED TO RECRUIT MOST OF OUR TEACHING FACULTY FROM AMONG THESE FOREIGN STUDENTS.

TO PUT IT BLUNTLY, WE ARE EATING OUR SEED-CORN. MINERALS EDUCATION NEEDS STRONG SUPPORT AT THE GRADUATE LEVEL TO ATTRACT HIGH QUALITY AMERICAN STUDENTS SO WE CAN REPLACE THE LARGE PERCENTAGE OF OUR FACULTY WHO WILL RETIRE IN THE NEXT DECADE. OUR UNIVERSITIES ARE LOOKING TO SOME MEANS WHEREBY THEY CAN INCREASE STIPENDS TO A LEVEL THAT WILL ATTRACT THE AMERICAN GRADUATE, WHILE THEY ARE FACED WITH DECLINING SUPPORT FROM FEDERAL AND STATE GOVERNMENTS.

FEDERAL SUPPORT FOR MINERALS DISCIPLINES IS CENTERED AT PRESENT IN TWO PROGRAMS: THE MINING AND MINERAL RESOURCES AND RESEARCH INSTITUTES AUTHORIZED BY TITLE III OF THE SURFACE MINING CONTROL AND RECLAMATION ACT OF 1977, AND THE DOMESTIC MINING AND MINERAL FUEL CONSERVATION FELLOWSHIPS AUTHORIZED BY TITLE IX OF THE HIGHER EDUCATION ACT OF 1965 AS AMENDED.

WE ARE DEEPLY CONCERNED ABOUT THE FUTURE OF BOTH PROGRAMS. THEY ARE NOT MUTUALLY EXCLUSIVE. THE INSTITUTES, WHICH RECEIVE ALLOTMENT, SCHOLARSHIP, AND RESEARCH FUNDS, ARE EXTABLISHED IN ONLY 31 STATE INSTITUTIONS, WHILE THE MINING FELLOWSHIPS MAY BE AWARDED TO ANY SCHOOL THAT HAS A GRADUATE PROGRAM IN AN APPROPRIATE DISCIPLINE. BOTH PROGRAMS ARE OF GREAT IMPORTANCE TO MAINTAINING QUALITY EDUCATION FOR AN AREA OF THE ECONOMY THAT IS OF INCREASINGLY CRITICAL IMPORTANCE TO OUR NATIONAL SECURITY AND SOLVENCY.

DOMESTIC MINING AND MINERAL FUEL CONSERVATION FELLOWSHIP PROGRAM

THESE FELLOWSHIPS PROVIDE MINIMAL SUPPORT FOR GRADUATE STUDENTS, CONSISTING OF A $4,500 STIPEND AND $3,900 INSTITUTIONAL ALLOWANCE. THE FUNDING FOR FISCAL YEAR 1980 WAS FOR 282 FELLOWS, INSUFFICIENT TO PERMIT FUNDING OF STUDENTS AT EACH QUALIFIED SCHOOL (ONLY 41 INSTITUTIONS WERE AWARDED FELLOWSHIPS), BUT CERTAINLY A LEVEL THAT SHOULD BE CONTINUED OR INCREASED. THE ELIMINATION OF THESE FELLOWSHIPS WILL PROBABLY RESULT IN A REDUCTION OF 200

TO 250 GRADUATE DEGREES EACH YEAR IN MINERALS DISCIPLINES, A PRICE THIS COUNTRY MAY FIND FAR EXCEEDS THE COST OF THE PROGRAM.

WE STRONGLY RECOMMEND THAT STIPEND LEVELS BE MAINTAINED OR INCREASED, EVEN AT THE COST OF SOME REDUCTION IN THE INSTITUTIONAL ALLOWANCE.

THE 1980 AMENDMENTS TO THE LAW STIPULATED THAT NEED MUST BE DEMONSTRATED TO JUSTIFY A $4,500 STIPEND TO ANY PARTICULAR STUDENT. THIS REQUIREMENT WILL PLACE AN EXTRA ADMINISTRATIVE BURDEN ON THE UNIVERSITY AND THE STUDENT. MOST PROSPECTIVE STUDENTS FACED WITH A CHOICE OF PROVING HIS NEED FOR AN INCOME OF $4,500 OR ACCEPTING AN INDUSTRIAL SALARY EXCEEDING $20,000 WILL LEAVE THE UNIVERSITY. I BELIEVE THIS DEFEATS THE PURPOSE OF THE ORIGINAL ACT--TO INCREASE THE NUMBER OF MASTER'S AND DOCTORAL DEGREES IN THE MINERALS DISCIPLINES.

Statement of Orest G. Komarnyckyj, Representative on Legislation, American Student Dental Association

My name is Orest Komarnyckyj and I am a fourth year dental student at Indiana University. As the American Student Dental Association Representative on Legislation, I am pleased to have the opportunity to present written testimony for your consideration during the budgetary process.

ASDA is the nation's largest independent organization of dental students. Our more than 18,000 members include more than 80 percent of the predoctoral student population. We have chapters at all 60 U.S. dental schools.

My testimony today concerns President Reagan's budget proposals for student assistance programs under the jurisdiction of this committee. We believe that the sharp cut in funding for student assistance being considered is a serious threat to dental education.

COSTS OF DENTAL EDUCATION

Dental education is very expensive now and costs are increasing at a rapid rate. Costs at some institutions are outpacing inflation by a significant amount. Average tuition at both private and public institutions has increased 140 percent over the last six years.

According to a report by the Council on Dental Education of the American Dental Association, the first year's tuition at a U.S. dental school for residents of the state where the school is located is $4,393; mean tuition costs for non-residents is $5,687.

Textbooks and fixed fees for the first year student average $2,857. The average first year dental student must pay $8,544 -- exclusive of living expenses. These estimates are not merely theoretical statistics. To take a specific example, a first year student at Washington University Dental School faces fees totaling nearly $11,000, exclusive of room and board. The costs of dental education are intimidating.

MEANS OF FINANCING DENTAL EDUCATION LIMITED

The rigorous dental school curriculum offers little time for outside employment while in school. Most programs keep dental students in school from 8-5 Monday through Friday, expecting students use their remaining time in study or preparing technical laboratory projects enabling them to master the technical aspects of dentistry.

Earning tuition in the summer is also not an alternative for middle income students, since many schools run programs year-round.

EXISTING LOAN PROGRAMS OFFER ONLY ALTERNATIVE

Lack of other alternatives compel dental students around the nation to rely heavily on low interest student assistance to attain their education. Access to adequate funds is, therefore, critical for most dental students.

The proposed recissions in the Guaranteed Student Loan Program and the phasing out of funding for the National Direct Student Loans will leave dental students with few viable options for obtaining funds. Competition for the funds the Administration proposes to eliminate is already keen.

At a time when the student population is increasing, educational costs are soaring; dental students facing high tuition and fees are finding themselves stranded in the middle of their education.

Failure to fund the Health Profession Student Loan Program (HPSL) authorized under the Health Manpower Law will accentuate the problem for those who are forced to use this as a funding mechanism. While the HPSL was originally designed to increase the number of health professionals, it quickly became one of the few viable sources of needed financial aid for many students.

ASDA is concerned about the catastrophic consequence changes in appropriations for student assistance programs pose for dental students in school and those about to enter. We urge that funding of dental HPSL in its current form be continued, not as a vehicle for increasing the number of health professionals, but as a vital part of a dental student's assistance package.

ASDA hopes that you understand the predicament dental students face if the proposed funding changes in student assistance programs go into effect.

Thank you for this opportunity to present testimony.

STATEMENT OF FREDERICK S. KLINE, DIRECTOR, SOCIETY FOR EXCELLENCE IN EDUCATION

Mr. Chairman and members of the subcommittee, the Society for Excellence in Education (SEE) represents students, effective educators and taxpayers who are concerned with the improvement of educational opportunities without additional inflationary pressures. These recommendations are designed as amendments for FY 1982 Elementary and Secondary Education Appropriations which will prevent unnecessary discrimination and expenditures.

(1) School districts that collect data on any ethnic groups for personnel vacancies and promotions must include all ethnic groups. The practice of listing merely a "white" category for for various reports, including those required by the Equal Employment Opportunity Commission, can result in continued discrimination on the basis of national origin. A supplementary question that covers ethnic origin is needed and can be compared with population data from the 1980 Census which recorded third and later generations as well as merely the first two for ancestry.

Approximately 20% of Detroit's population is of Slavic ancestry but only a negligible representation of administrators employed by the Detroit Board of Education are of Slavic national origin. A class action suit against the Detroit Board of Education for discrimination against qualified Slavic educators is before the United States Sixth Circuit Court of Appeals.

(2) School districts that engage in collective bargaining must have contract agreements for all personnel units for the school year. A disruption of the educational process during the school year results in a waste of taxpayers' money.

(3) School districts must demonstrate annual average academic achievement progress of 150% of 1980 based national norms for all students in regular classes, through the eighth grade. An amendment that requires definite achievement progress will prevent unnecessary expense for taxpayers to repair the damage caused by ineffective instructional programs.

STATEMENT OF SCHOOL BOARD, BREVARD COUNTY, FLA.

Executive Summary

- Located in the Ninth Congressional District on the East Coast of Florida
- Kennedy Space Center, Cape Canaveral Air Force Station and Patrick Air Force Base located in Brevard
- 10th largest School District in Florida
- 62 schools serving 46,725 students

Federally-Connected Students:

Type	Number of Students
"A" (Parents work-on, live-on Federal Property)	1,479
"B" (Parents work-on, live-off Federal Property)	10,886
	12,365 (26.5% of total district student population)

Revenue received (including Impact Aid) by School Districts in 1978-79 for each Full-Time Equivalent (FTE) Student was:

Revenue Source	Amount Per FTE Brevard	Amount Per FTE State Average	Brevard Ranking in State
Federal	$ 181	$ 201	47th
State	980	933	36th
Local	557	675	33rd
Total	$1,718	$ 1,809	48th

Brevard County is 5.0% below the State average in funds received from all sources, including Impact Aid. The major cause of this is at the local level where we are 17.5 % below the State average.

The value of taxable property is the major factor in determining local funds received by the district. The taxable property per

FTE in Brevard is $82,000 compared to the State average of $101,000.

The assessed property value in Brevard for 1980-81 is $9.4 billion of which only $4.1 billion is taxable. Of the total acreage in Brevard County, approximately 22.4% (146,723 acres) is exempt from the tax roll by three major Federal installations:

- John F. Kennedy Space Center
- Cape Canaveral Air Force Station
- Patrick Air Force Station

The acreage removed from the tax roll by these Federal installations amounts to 30% ($2,813,686,089) of the total assessed property valuation for the county.

Were this acreage taxable, Brevard County would receive an additional $16.3 million in local funds. Currently, Impact Aid appropriations will provide $2.3 million in lieu of taxes.

Under Former President Carter's proposal to eliminate Category "B" funds, $1.2 million would be lost. This would have a serious effect to the local school district which is already seriously affected by the loss of taxable property due to the Federal Government.

Even when Impact Aid is added to local Ad Valorum tax revenues, Brevard is $113 less than the state average of Districts not receiving Impact Aid. (See Addenda D, E, & F)

Recommendations:

1. Include hold-harmless provisions in the FY-82 appropriations for PL 874.
2. Fund Low-Rent Housing payments without provisions that funds be expended on Title I type programs.
3. Appropriate at least $856 million for Impact Aid. This amount will only provide funding at the FY79 level.
4. Disapprove any proposals which would fund the program based on percentages of school districts' operating budget.

5. Make no substantial changes in PL874 until you have studied the report from the Commission on the Review of the Federal Impact Aid program.

For additional information, contact Mr. John N. Forbes or George A. Estle, (305) 631-1911.

I. Geographic Information

Brevard County, Florida - - - is located in the Ninth Congressional District along the Eastern Coast of the Florida Peninsula. It is 72 miles north to south and averages 18 miles east to west.

The entire county encompasses a single school district as do all counties in Florida. (67 School Districts with 1,540,189.88 FTE units estimated for 1980-81).

The Brevard County population is approximately 270,000. The major single industry located within the county is the aerospace industry which is located on north Merritt Island and in the north beach portions of Brevard County. This aerospace activity consists primarily of ballistic missle testing and the launching at the Cape Canaveral military complex in the ocean beach area, and civilian space exploration located on the Merritt Island Kennedy Space Center Complex.

During 1981, a new era of space exploration will begin with the launch of the space shuttle scheduled for mid April.

II. Federal Government and Brevard County

The student enrollment in Brevard County was 8,500 in 1955-56 and increased to 62,500 in 1969-70. This represents an increase of 635 percent.

This growth was primarily due to the impact of federal activities at the Kennedy Space Center. During this 15 year period, the number of schools increased from 15 to 67. The School Board of Brevard County committed itself to school construction expenditures which will not be paid until the year 2002. (See Addendum A).

Whereas many areas of the county have experienced a decline in student population, Brevard's irregular pattern of a population explosion followed by a sudden loss of students is directly a result of federal activities at Kennedy Space Center.

The overnight move-out of government personnel caused stability and financial problems for the county school system. The number of federally-connected students has declined from 23,500 in 1971-72 to 12,365 in 1980-81. (See Addendum B).

Seven schools have been closed within the last three years, primarily in the North and Central areas. All of these schools were completed during the high growth period and increasing federal activity. We will continue to pay the debt on most of these facilities even though they are no longer in use. Therefore, the burden of paying for the schools which were necessary to house students during this period of growth is left to the remaining local taxpayers.

The federal government owns 22.4 percent, 146,723 of the 653,627 acres, of the dry land area in Brevard. The value of the federal government property is $2.8 billion, which represents 30% of all the property value in Brevard County. The taxable property per FTE in Brevard is $82,000 compared to the state average of $101,000. (See Addendum C).

Much of this land is prime, ocean-front property. If the school district received federal aid equivalent to the tax value of the federal property in lieu of taxes, it would provide an additional $16.3 million per year. Under the present impact aid program, we have received $2.3 million for the 1979-80 school year.

The Brevard County School District serves 1479 "A" students(Parents who work-on and live-on federal property) and 10,886 "B" students (Parents who work-on but live-off federal property) for a total of 12,365 federally-connected students or 26.5 percent of the total student population. In FY-80 Brevard's entitlement for payments include $1,124,698 for "A" students and $1,196,348 for "B" students for a total of $2,321,046. If the "B" payments were eliminated, as proposed by the Carter Administration for FY-82, Brevard County would lose $24 per student. With this loss of revenue per student the result would be a higher pupil-teacher ratio in classrooms, fewer teaching supplies and delays in maintenance, to name a few.

III. Summary

As we have demonstrated, Impact Aid, which is one of the most long-standing federal assistance programs to education, has provided school districts with needed resources to pay for added costs resulting directly from federal activities.

The Brevard County School system's original problem was the impact of students. Today's problem is the impact of non-taxable land.

The proposed drastic reductions would have serious and perversive effects on education. Therefore, we respectfully request that you actively support and vote for the following:

1. Include hold-harmless provisions in the FY82 appropriations for PL874.
2. Fund Low-Rent Housing payments without provisions that funds be expended on Title I type programs.
3. Appropriate at least $856 million for impact aid. This amount will only provide funding at the FY79 level.
4. Disapprove any proposals which would fund the program based on percentages of school districts operating budgets.
5. Make no substantial changes in PL874 until you have studied the report from the Commission on the review of the Federal Impact Aid Program.

On behalf of the Nation, the State of Florida, and Brevard County, thank you for your time.

ADDENDUM A

BREVARD COUNTY SCHOOL DISTRICT

Total Student Membership
K - 12

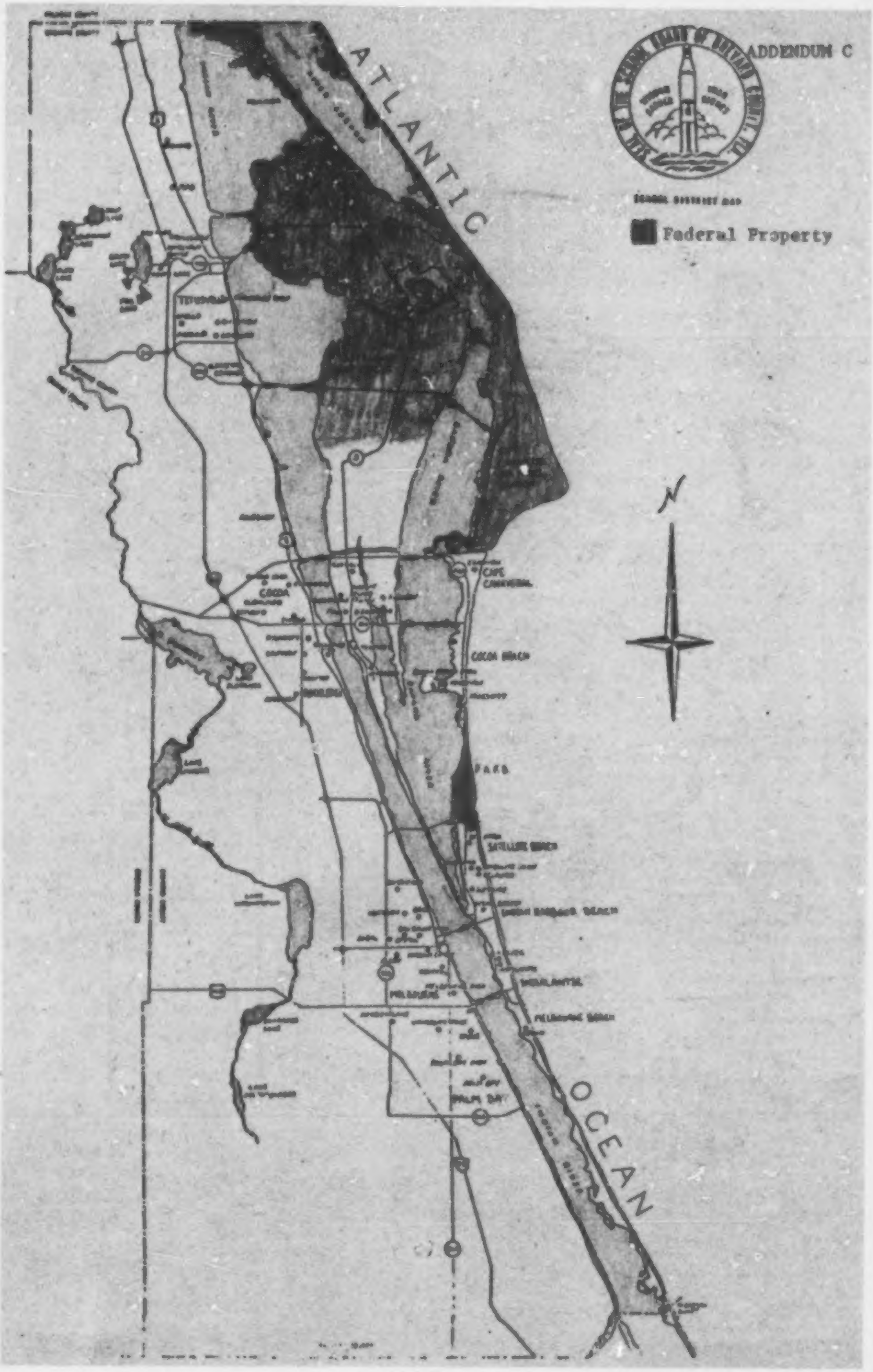
Fiscal Year	Beginning	Ending
1955-56	8,529	8,643
1956-57	11,046	11,786
1957-58	13,940	14,960
1958-59	17,638	17,974
1959-60	21,005	21,372
1960-61	23,742	24,150
1961-62	27,132	27,996
1962-63	32,386	33,538
1963-64	39,007	40,278
1964-65	45,451	45,506
1965-66	50,335	51,252
1966-67	56,443	56,072
1967-68	61,517	59,512
1968-69	62,408	60,686
1969-70	62,492	59,978
1970-71	61,511	59,993
1971-72	61,959	60,774
1972-73	62,285	60,149
1973-74	60,282	57,833
1974-75	57,335	55,672
1975-76	54,766	52,942
1976-77	52,623	51,700
1977-78	51,179	50,315
1978-79	49,731	48,966
1979-80	48,520	47,683

Sources:
1. Annual Reports of the Commissioner of Education.
2. School District Monthly Reports of Attendance - 1955-77.
3. Fall Student Membership Survey - 1978-79.
4. Impact Aid Survey - October 1979.

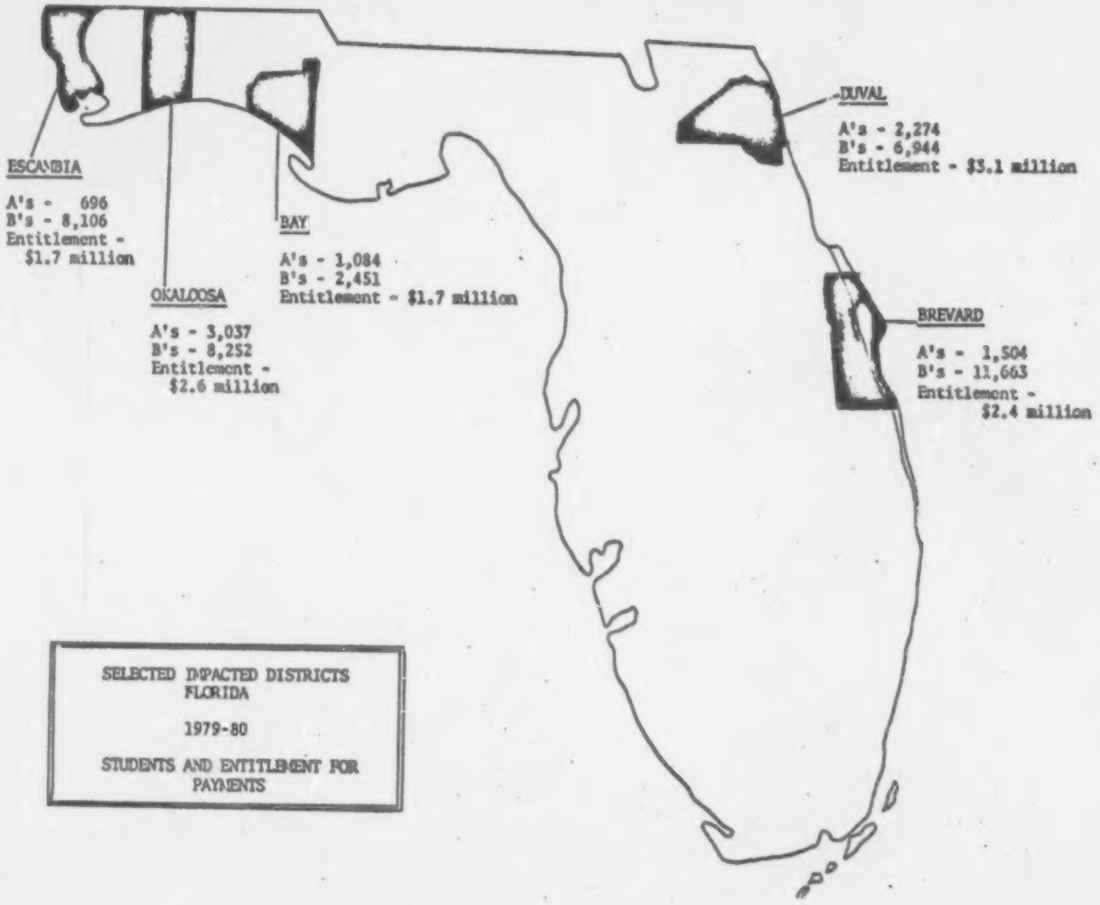
ADDENDUM B

BREVARD COUNTY SCHOOL DISTRICT

Year	Membership	Number of Federally Connected Students			Federally Connected Students as a Percent of Total Membership
		Type A	Type B	Total	
1971-72	61,959	2,046	21.600	23.646	38.16%
1972-73	62,285	2,012	20,339	22,351	35.89%
1973-74	60,282	1,966	16,506	18,472	30.64%
1974-75	57,335	1,801	13,879	15,680	27.35%
1975-76	54,766	1,685	13,294	14,979	27.35%
1976-77	52,623	1,822	12,845	14,667	27.87%
1977-78	51,179	1,766	12,498	14,264	27.87%
1978-79	49,731	1,637	12,046	13,683	27.51%
1979-80	48,520	1,504	11,663	13,167	27.14%
1980-81	46,725	1,479	10,886	12,365	26.46%


ADDENDUM C
▇ Federal Property
ATLANTIC
OCEAN
N
TITUSVILLE
COCOA
ROCKLEDGE
CAPE CANAVERAL
COCOA BEACH
PAFB
SATELLITE BEACH
INDIAN HARBOUR BEACH
MELBOURNE
INDIALANTIC
MELBOURNE BEACH
PALM BAY

ADDENDUM D


ESCAMBIA
A's - 696
B's - 8,106
Entitlement - $1.7 million
OKALOOSA
A's - 3,037
B's - 8,252
Entitlement - $2.6 million
BAY
A's - 1,084
B's - 2,451
Entitlement - $1.7 million
DUVAL
A's - 2,274
B's - 6,944
Entitlement - $3.1 million
BREVARD
A's - 1,504
B's - 11,663
Entitlement - $2.4 million

SELECTED IMPACTED DISTRICTS
FLORIDA

1979-80

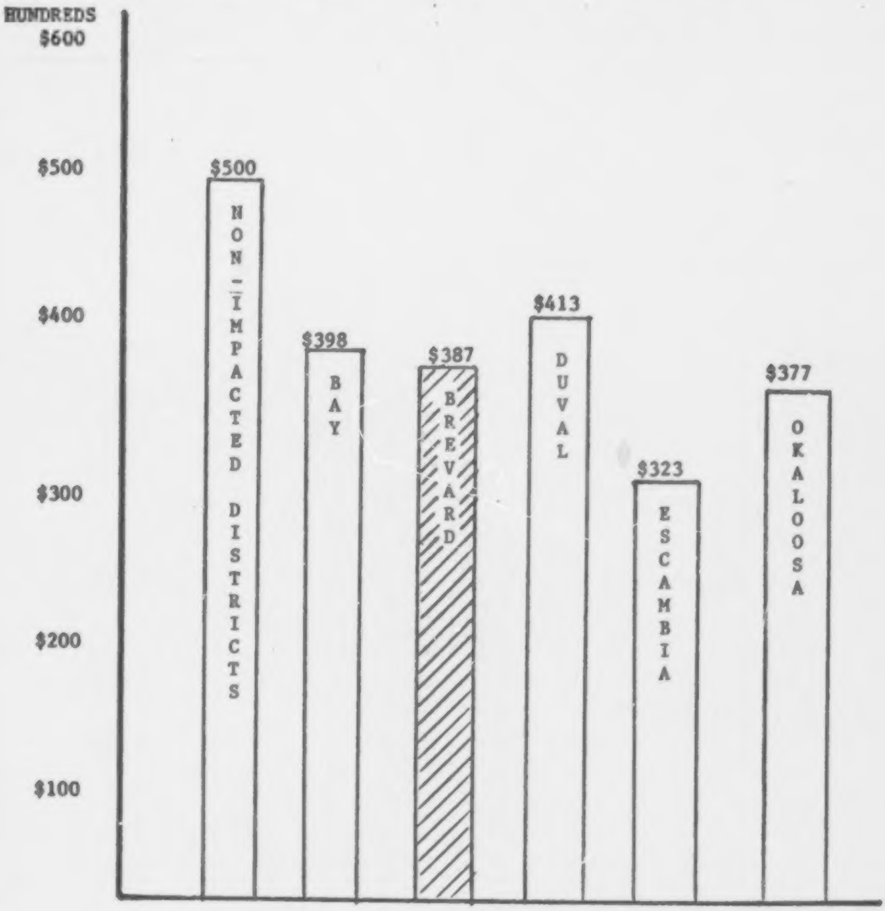
STUDENTS AND ENTITLEMENT FOR PAYMENTS

ADDENDUM E

1979 - 1980

AD VALOREM TAX YIELD AND IMPACT AID PER FTE
(6.75 MILLS)

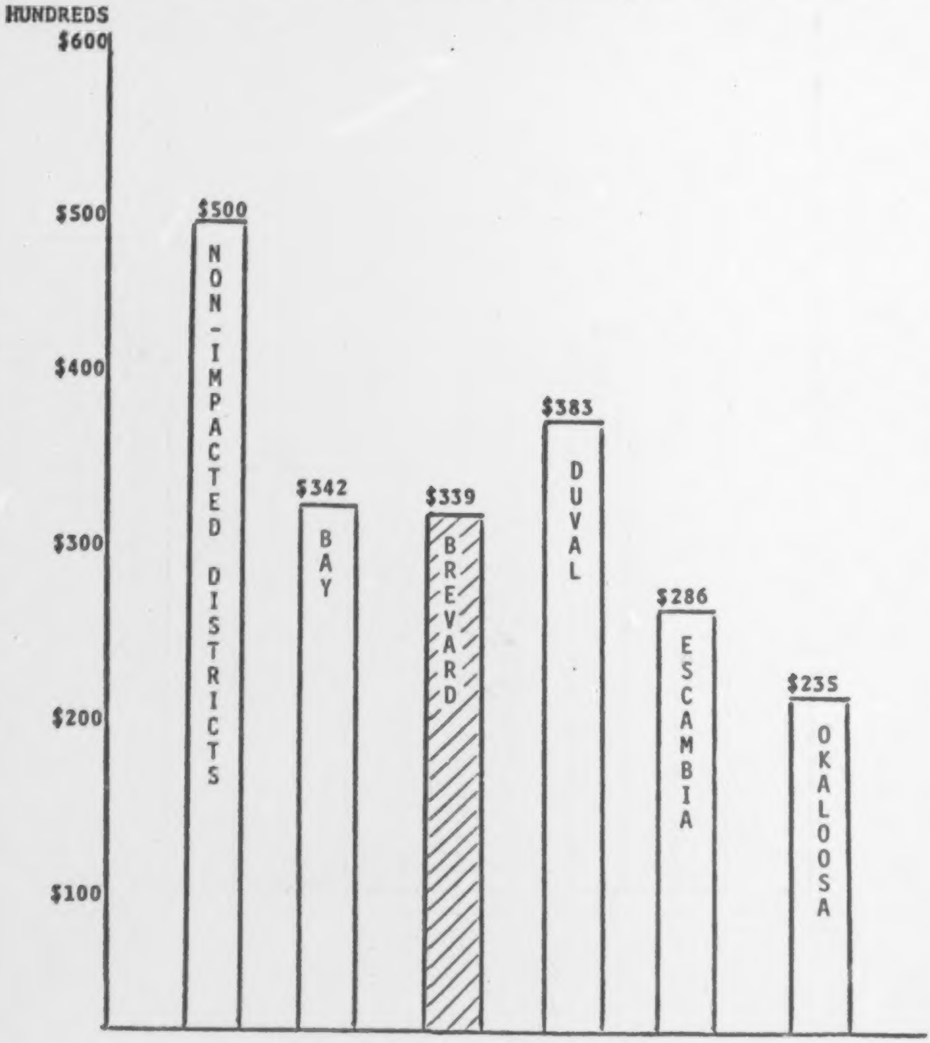
SELECTED IMPACTED DISTRICTS VS AVERAGE OF NON-IMPACTED DISTRICTS



ADDENDUM F

1979-80

AD VALOREM TAX YIELD PER FTE
(6.75 MILLS)
SELECTED IMPACT AID DISTRICTS VS AVERAGE OF-NON-IMPACT DISTRICTS



STATEMENT OF SIERRA SANDS UNIFIED SCHOOL DISTRICT, RIDGECREST, CALIF.

The Sierra Sands Unified School District appreciates this opportunity to present testimony to this distinguished committee.

It is important to examine the history of China Lake and Ridgecrest, California, and the Naval Weapons Center in order to fully understand the impact of the Naval Weapons Center upon the Sierra Sands Unified School District. Once this history has been outlined, the most important impact, that of Sierra Sands on the Naval Weapons Center, can be appreciated.

History

At the beginning of World War II the War Department established the Naval Ordnance Test Station in the remote reaches of the Upper Mojave Desert upon the bed of the dry China Lake. Before the Navy arrived there was nothing but sagebrush and rabbits. A laboratory complex and a series of test ranges were carved out of the desert, and over a period of 25 years it evolved into what is now known as the Naval Weapons Center. Three thousand one hundred and seventy-two living units have been constructed on the Center, together with schools, recreational facilities, roads, sewer systems, power and utilities, shopping, church and banks--all the normal amenities of community life. The entire community was built and run by the Federal Government solely to operate the Naval Weapons Center.

Sierra Sands Unified School District with headquarters in Ridgecrest is 80 miles south of Mount Whitney, 80 miles west of Death Valley, 80 miles north of Lancaster and adjacent to Edwards Air Force Base. Ninety percent of the land area within the school boundaries is owned by the Federal Government.

A small service community, Ridgecrest, grew around the periphery of the Center. Prior to 1974 very few NWC employees lived in Ridgecrest because construction funds were simply not available for housing. But around 1974 two changes took place. Mortgage money finally became available, a developer appeared in the Valley, and the Navy changed its housing policy to systematically force its civilian employees to move from inside the China Lake fence out to Ridgecrest. Thousands of families left the Center, until over 1600 homes have been vacated in China Lake.

The Impact of the Naval Weapons Center on Sierra Sands School District

The impact of the Navy policy of moving families from China Lake to Ridgecrest was cataclysmic to the Sierra Sands Unified School District. Virtually overnight the District went from Super "A" category to "B" category. The shift in housing pattern from base residence to city residence has made a minor increase in the assessed value, but not a significant enough increase to offset the difference in funding of "A" students and "B" students. The clients of the school district remain the families of the Naval Weapons Center personnel. Nearly 70% of our children are federally connected. The Sierra Sands School District has an enrollment of 5400 students in grades kindergarten through the twelfth grade.

The proposed appropriations for the 1982 fiscal year for P.L. 874 school impact funds provides continuance for assistance to heavily impacted districts, those in the Super "A" category ("A" students being more than 20% of enrollment). The proposal eliminates all funds for "B" category students and for districts with less than Super "A" status. There are a small number of school districts (approximately 12) nationwide who are very heavily impacted (50% or more of enrollment), and who do not qualify as Super "A" districts. They would lose all impact funds. In the case of Sierra Sands Unified, this loss of funds would be approximately $1.9 million. In order that we may continue to serve the children of the Naval Weapons Center with a quality educational program, it is urgent that language be included in the appropriations bill to provide continuance of funding for those few districts who are heavily impacted but do not qualify as Super "A".

The Federal Government has forced a change in the living patterns in the Valley without change in the relationship of the populace to the Naval Weapons Center. NWC is still the largest employer in the entire area.

The community served by the Sierra Sands Unified School District is a pure creature of the Federal Government and is a classic "company town".

Consider these facts:

- the Naval Weapons Center is the largest employer in the Valley, with almost 4000 civilian employees and a payroll of $133 million in FY 81;
- Sierra Sands Unified is the next largest employer at about 700 employees with a payroll of about $10 million;
- the next largest employer is a hospital;
- about half of the private enterprises in the community are contractors serving the Naval Weapons Center;
- four school sites are inside the Center fence and two are just outside on property owned by the Federal Government;
- the City of Ridgecrest is tied into the NWC sewer system; most of the community's recreational facilities are inside the fence.

The conclusion is obvious; unlike many other impacted school districts, Sierra Sands exists only to serve the Navy. If the Navy abandoned China Lake, all of Ridgecrest (including the school district) would vanish overnight.

The Impact of Sierra Sands on the Naval Weapons Center

The Naval Weapons Center is not going to disappear; it is a permanent Department of Defense installation, and its importance to the Navy increases yearly. It is the Navy's principal research, development, test, and evaluation center for air warfare systems and missile weapons systems. Major programs include the Sidewinder AIM-9 series, SPARROW, AMRAAM, WALLEYE, HARPOON, and SHRIKE, to list just a few. Its ranges are among the best instrumented and most extensive in the free world.

As President Reagan increases spending on defense, the Naval Weapons Center will be required to grow and manage an ever-larger share of the load. It will be necessary to hire more civilian engineers and scientists, and NWC will need to keep the highly-trained enlisted personnel who man the planes and ranges. The type of people who are now employed here and who will be sought in greater numbers in the near future are those who value a sound, challenging education for their children. Moreover, these same people will be sought by every other defense contractor in the country; NWC will have to compete for desirable people to carry out its mission. Wages are not high in Federal Civil Service for this area and, if the schools are not excellent, there will be nothing to entice and attract good people to the Valley.

Thus, education in Sierra Sands will have a direct and immediate impact on defense. The ability of the Navy's primary air-to-surface missile center to perform its mission will be diminished because the Federal Government will not have done its part in keeping the schools at the same level it will keep its laboratories. It is important, therefore, that the Senate carefully consider how Impact Aid to Sierra Sands Unified is directly related to defense.

PAGES EXTRACTED FROM STUDY PREPARED BY THE
ECONOMIC ADJUSTMENT COMMITTEE, 1979

Housing

Absence of a housing demand analysis makes an accurate assessment of the impact difficult. However, it is certain that the Navy housing policy changes will result in an increase in the city's housing stock. If local or state governments do not exercise the option to develop the excess housing units for public reuse the area could very quickly deteriorate; therefore, the Navy and GSA should move quickly to assure the reuse of the area.

Education

The effects of policy changes upon education have been experienced principally by the Sierra Sands Unified School District. These effects have been a loss of revenue related to Public Law 81-874, increased transportation costs, and inconvenience and antagonism introduced by base access pass procedures.

Loss of revenue has resulted from the changed eligibility of the school district for federal funding under the Impact Aid Program, Public Law 81-874. When students and/or parents move off of a federally owned base, the Impact Aid payment is reduced. The various categories of aid under the law are shown in Appendix Table C-29. Percentages therein refer to the percentages of Local Contribution Rate (LCR) per pupil which can be provided by the U.S. Department of Health, Education and Welfare (HEW) under Public Law 81-874. This LCR is computed by HEW for eligible districts.

As population shifted from the base (NWC) to Ridgecrest, eligibility of the school district under Public Law 81-874 declined sharply. In September 1974, category 3A students (those students whose parents reside on federal property) represented 45 percent of the impacted aid student population and category 3B students (those students whose parents work on federal property but reside elsewher) represented 55 percent. As of the current school year category 3A students represent only 26 percent of the student aid population while category 3B students now represent 74 percent. Based upon current student enrollments, there has been a net shift of approximately 550-600 students from China Lake (NWC) to Ridgecrest. This represents approximately 10 percent of the total student enrollment of the district.

The shift in student enrollment from category 3A to category 3B results in a loss in entitlement funding. Entitlement funding for category 3A students is 100 percent of LCR and for category 3B students is only 45 percent. Thus, each student shift from category 3A to 3B results in a 55 percent loss of entitlement funding for that student (see Appendix Table C-29).

The population shift and loss of 3A student population have resulted in a decline of entitlement funding from 100 percent to 90 percent for students of civilian employees living on base.

The Impacted Aid Program is funded within a three-tiered funding structure. These tiers are funded in order of priority. Tiers one and two have historically been fully funded while tier three has seldom been funded.

The shift from category 3A student enrollment to category 3B and the loss of 100 percent entitlement for civilians on base cause a shift in dependence for entitlement funding from tiers one and two to tier three with a net loss of entitlement funding.

The Sierra Sands Unified School District cannot recoup the loss of entitlement revenue by increased property tax revenues. California Senate Bill 90 and recently enacted Proposition 13 place a ceiling on the amount of revenue school districts can raise by way of property taxes. The Sierra Sands Unified School District is already at the ceiling. As a result, the district does not realize additional increases in revenue that would be anticipated from increases in property valuation as residents move from China Lake and purchase homes in the Ridgecrest area. The net effect of the population shift is a loss of entitlement revenue with no compensating increase from property tax revenues.

Further aggravating its revenue loss, the Sierra Sands Unified School District has been disqualified by HEW from receiving approximately $185,000 under the Hold Harmless provision of the Supplemental Appropriation Bill of 1976. The Hold Harmless clause provided that school districts whose budgets are made up of at least 10 percent Public Law 81-874 revenue be guaranteed at least 90 percent of the preceding year's prorated entitlement beginning after June 30, 1974 and ending July 1, 1978. This provision would have provided approximately $185,000 to the school district. HEW has disqualified the district because the Rand District (50 students), one of the four school districts that was unified to form the Sierra Sands District, was not an applicant district in 1973-74. This disqualification should be re-evaluated since unification was mandated by the State of California.

Accompanying the loss of revenue to the unified district is an increased cost for student transportation. Four of the ten Ridgecrest area schools remain at NWC although the concentration of students has shifted to Ridgecrest. Consequently, total student-miles of transportation have increased.

Statement of Board of Directors, Parents' Campaign for Handicapped Children and Youth

The Parents' Campaign for Handicapped Children and Youth represents "consumers," i.e., handicapped persons, parents and other advocates of handicapped learners, and professionals in the field. We are in touch with families, in every part of the country, who are directly affected by disabling conditions of a wide range of type and severity. Typically they have experienced severe financial burdens as the direct result of disabling conditions, as well as traumatic emotional concern — and they must expect more of both. We are lifted and inspired by the courage and imagination of hundreds of these families who are working hard and with determination to protect and develop the intellectual and spiritual and physical resources of the handicapped member — to develop self reliance and to maximize lifetime contributions to the community and the nation.

The seven members of the Board of Parents' Campaign include family members of disabled persons from young children to adults, a disabled adult, men and women of varied geographic locations, races, and disabilities which they have personally experienced. The Board members practice in a wide range of professions, and all have dealt professionally with aspects of information and education for the handicapped.

Productivity

A major goal of this Administration is a strong boost to U.S. productivity, as we understand it, as a key to resurgence in the national economy. An integral element in a more productive economy, we suggest, is a work force that is better educated including the capacity for continuing learning, that is self-reliant and is competent in human relations. For example, innovations in processes for detailed operations, especially in the services which account for an increasing portion of U.S. output, tend to be initiated on the job by alert and motivated people directly involved in the work. Modern trends toward greater worker participation in work planning and organization seem to be especially important to increasing productivity, especially in circumstances of unpredictable changes in work activities and circumstances. These more effective approaches depend strongly on workers' abilities to work in teams and to learn new techniques and relationships as needed.

We encourage the Congress to consider with some care alternative possibilities for strengthening our national systems for human development, and for research and development; building stronger systems is, we believe, a common concern. We recognize that you have a large responsibility to exercise reasonable caution against reckless or radical tampering with the social structure, while at the same time fostering potentially beneficial new ideas. Because of our conviction that human development is the fundamental resource, we hope that the Administration and the Congress will concur in a stronger emphasis on education and rehabilitation than is embodied in the Administration's budget rescission proposals, necessarily developed quickly and under strong pressures to achieve very large aggregate reductions.

Education of the Handicapped

The particular primary concern of Parents' Campaign for Handicapped Children and Youth is in education for the handicapped. The dominant item is for state grants under Part B of 94-142, to support special education by LEAs and support services and direct services by SEAs. Public Law 94-142 was adopted late in 1975, to implement ". . . the national interest that the Federal Government assist State and local efforts to provide programs to meet the educational needs of handicapped children in order to assure equal protection of the law."

The estimate of average relative cost for adequate education of the handicapped was 50% in excess of the general average for pupil expenditure. The Act provided for phasing in aid amounting to 5% per capita for the year ending September 1978, to increase to 40% per capita for the year ending September 1982. Thus the full authorization under the act provided for State and local sources to bear, for handicapped children, not only the basic average per capita costs for children of all types, but additional amounts of 20% and more up to this time.

Moreover, the Act emphasizing the mainstreaming of handicapped children to the maximum extent appropriate, as well as other desirable advances, called for very significant changes — ones which have been slow to be realized in some locations. In retrospect, it seems to this writer that the needs for training and development of services and materials to support the teachers and administrators were not appreciated and were underestimated; some teachers felt beleaguered, some children suffered; effective implementation of the Act is incomplete in some places. In this context, we suggest that the Education for All Handicapped Children Act is not an appropriate candidate for budget "savings" — the Law should be fully implemented, requiring more money, not less.

The national interest continues. The accident of chance concentration of handicapped children imposes sizeable additional costs of schooling. The insurance principle suggests that in equity the national body politic should share in the excess costs. Handicapped children, in most cases, are mobile. They are likely to live and work and act as citizens in communities other than their place of education — so the adequacy of elementary-secondary education affects others beyond the boundaries of the terms of origin. The national interest has another aspect. Handicapped young people have on the whole been unable to develop their full potentials, to make the contributions to production, to creativity, to community life and politics that their intrinsic talents and personalities would enable them to do, for lack of educational opportunity. The exceptions which all of us know are simply illustrations of the potentials which could be realized in many more instances.

Another way of expressing this claim that education of the handicapped offers exceptional benefits is in terms of economic cost-benefit analysis. The attached article "Dollars for Independence" summarizes the evidence that, from the standpoint of the society, dollars spent to enable the disabled to become independent have a big pay-off to the economy and a substantial net income to the national treasury as the result of income tax payments and costs precluded for income maintenance and other services, in excess of the expenditures for education, vocational education, and rehabilitation and training.

Summary

In short, we urge support of the recommendation of the Senate Committee on Labor and Human Resources for a 10% increase in appropriations for handicapped education and other programs for the disabled. We believe such action would contribute positively to the President's goal of increasing productivity. This is a way to support family responsibility, to recognize human dignity. Above all, such action honors our national values by expressing human concern in a meaningful way for our fellows who need and deserve it.

Dollars for Independence

Newspapers and magazines are filled with articles commenting on the high cost of programs for people with disabilities. Double digit inflation and the declining value of the dollar have made everyone, from legislators to the average citizen, call for a tightening of the purse strings. However, cries of "You're spending too much money. Cut back!" run the risk of being penny-wise and pound-foolish.

Money spent on special education and rehabilitation programs decreases dependency and increases self-sufficiency. These dollars for independence transform the enormous potential of people with disabilities into productivity. Just as important as the monetary benefits to the economy in the form of taxes and avoidance of institutional costs is the self-esteem that results when a person becomes an integrated member of the community, contributing talents and skills as well as tax dollars. In financial terms alone, however, society cannot afford to overlook this untapped resource.

Barriers to Independence

The nation's failure to invest in the potential of disabled citizens is cited as a major cause of inflation and a central factor in the country's poverty problem by Dr. Frank Bowe, Director of the American Coalition of Citizens with Disabilities. In his recent book, "Rehabilitating America," he points out that one out of every thirteen dollars in the federal budget is spent on benefits for disabled people dependent on government aid, such as income-maintenance, medical support and related services. This is, he says, one of the largest contributions to the increase in federal spending.

Disability-related benefits provide important and necessary services for people with handicapping conditions so severe that they cannot live independently. However, many disabled people who can participate in the workforce are prevented from becoming independent tax paying citizens by lack of education and appropriate training programs, inaccessible public transportation, nonwork-related job requirements and work disincentives.

Education—a sound investment

Education in general can be viewed as an investment. In recent years, considerable research in the field of economic theory has focused on the links that exist between edu-

Dollars for Independence

(continued from page 1)

cation, productivity and income. Economist Gary S. Becker in his book "Human Capital" notes that highly educated and skilled persons tend to earn more than others. He goes on to point out that unemployment is strongly related to the lack of education. This may sound like plain common sense—and it is. Job skills command dollars in the marketplace.

The Education for All Handicapped Children Act of 1975 (Public Law 94-142) established the right of all American youngsters to an education. Its primary goal is to give every child, including the most severely handicapped, the learning opportunities needed to become as self-sufficient and independent as possible. Is there a way of showing that dollars spent on excess costs of special education programs are paid back to the government through income taxes and other channels? Research studies done during the last decade provide the basis for making such a projection.

Dollars make sense in special education

In a study done in 1970, Rossmiller, Hale and Frohreich surveyed 24 school districts in five states and found that the cost of special education programs ranged from 1.18 times to 3.64 times the cost of education of the so-called normal child, depending on the disability category. The *average* cost of special education was approximately twice that of regular education. David Braddock in his article "Dollars and Sense in Special Education" used Rossmiller's formulas for 10 disability categories as a basis for demonstrating that expenditures for the education of handicapped children produce a substantially positive return on investment. To demonstrate long-term savings, Braddock used the concept of the educational payback period—the amount of time necessary for an educational program to pay back its cost.

For example, Rossmiller estimated that it costs 2.97 times the cost of regular education to educate a visually impaired child. If the cost for regular education is $1,207, it would cost 2.97 times as much or $3,585. The excess cost would be $2,378 or the difference between the two. For a 12 year education program, the excess cost would be $28,536.

Research points to long-term saving

Taxes were calculated on a salary based on the federal minimum wage ($2.30 at the time of the study), and amounted to $1,121 for one year or $44,840 over 40 years, the average worklife of a person. By dividing the excess cost for 12 years ($28,536) by the taxes paid in one year ($1,121) a payback period of 25.5 years was determined. By subtracting the total excess cost ($28,536) from the taxes paid over a 40 year period by a visually handicapped person who had received an education through 12th grade ($44,840), a long-term saving of $16,304 was received by the community. If the estimated saving to the community in income-maintenance payments were added to this figure, there would be a total saving of $61,144. Thus, by spending more on a handicapped person's education, the community profits by $61,144 over the span of his or her working life.

In this study, the payback period for a speech impaired child was 2.3 years with a total long-term saving of $87,076; for a mildly retarded student it was 11.2 years, and when a mildly retarded child was taught academic and work skills instead of being placed in a custodial institution (a not infrequent event), a total long-term saving of $441,289 resulted. The average payback period in this study was found to be 25 years.

This analysis is hypothetical—it is based on a certain set of assumptions. Results will be different if any of the assumptions change: for example, if the visually impaired person earns more (or less) than the minimum wage, it will take a shorter (or longer) period of time to pay back the cost. However, it should be remembered that a person with a handicap will not necessarily have difficulty earning a living; many disabled but capable people will contribute in tax dollars well in excess of their individual education costs.

In any event, for all nonsevere disability categories in Braddock's analysis, projected taxes paid directly to the government, as well as indirectly through income-maintenance avoidance, exceeded the *total* cost of a 12 year education experience.

Early opportunities for development lead to success

Similar results have been demonstrated in other studies. Ronald W. Conley, author of "The Economics of Mental Retardation," reports that the lifetime earnings of mildly retarded adults are six times that of the cost of their education. He concludes that, *"Educational services to the mildly retarded can be justified on the basis of earnings alone. It is, in fact, self-defeating not to provide these services, since this would sacrifice a large long-run gain for a small short-run gain."*

The success of retarded people in employment is dependent on their having the opportunity for intellectual and social development in childhood and supportive services as adults. Evidence shows that there are very few intellectually handicapped individuals who do not have potential for gainful employment, and those who cannot actually join the labor force are usually capable of learning self-care skills which can help them to become better integrated into family life.

High quality education is good economics

There is no way to put a dollar value on the elimination of loneliness and futility by making it possible for a person to become a productive, social human being. But, it is becoming increasingly important to demonstrate the sound economics of spending public money for opening equal opportunities for handicapped individuals. The numbers point to a substantial dollar return on the investment in education of children with disabilities. How to do this most effectively is becoming an important topic for research.

A paper presented by Dorinda D. DeWitt and Wade C. Wieters to the World Conference on Future Special Education in 1978 reports on gains in achievement as well as cost savings in the comparison of two special education

(continued on next page)

Dollars for independence
(continued)

models—resource rooms and self-contained classes—in South Carolina. The high and low educable mentally handicapped students enrolled in the resource room program performed better on post-tests in reading, arithmetic, and spelling than their counterparts in the self-contained programs. In addition to producing higher achievement gains, the resource room program was less expensive to operate.

Interesting as it is, we should be cautious about leaping to conclusions based on this study. Comparisons must be restricted to populations and special education settings that are actually similar. We must always be vigilant about maintaining high standards—not seeking "bargain basement" savings at the sacrifice of meeting appropriate needs. What seems to be showing up as a fact is that quality and appropriateness in education *do* add up to good economics. The study does point to an important area for additional research in order to achieve the goal of high quality and cost effective education for children with special needs.

Vocational education—key to jobs

Dr. Daniel Taylor, Assistant Secretary for Vocational and Adult Education, recently commented, "Vocational educational programs are an important key for linking handicapped youngsters with occupational opportunities." Vocational education *can* be the means to an important end — a paying job. Unfortunately, handicapped youngsters are generally excluded from the regular public school vocational education programs and are limited to segregated classes offering few career choices. Lack of training can lead to lack of opportunity and unemployment.

A report to the Congress in 1976, prepared by the General Accounting Office, estimated that with vocational education, 75 percent of physically disabled and 90 percent of mentally retarded students are capable of working either in competitive employment or in sheltered workshops. However, of the more than 16 million individuals served by vocational education in 1978, only 2.1 percent were handicapped. The limited career opportunities that result from lack of training keep young people with disabilities unemployed or underemployed.

Employers prefer vocational graduates

According to the American Vocational Association, there is considerable evidence that vocational graduates have an advantage in the labor market over nonvocational graduates. A national survey of 23,000 students who graduated in 1972 reported that vocational graduates generally required less time to find their first job and earned more than other students. In 1976 the youth unemployment rate for high school students who completed vocational education programs was 13.5 percent as opposed to the 19.9 percent national rate for all 16 to 19 year olds. A 1978 survey of employers in Ohio indicated that 76 percent expressed a hiring preference for graduates with vocational education.

There is no question that handicapped students who have not chosen to attend college need vocational education and can benefit from it. It can be a deciding factor in landing that first job—and making it up the ladder to financial self-sufficiency.

Rehabilitation and training programs—transition to work

For over 60 years, vocational rehabilitation, a federal-state program, has been providing a wide variety of services to people with mental and physical disabilities to enable them to participate in gainful activity. As a result, many handicapped individuals have achieved a high degree of economic self-sufficiency, and the program has also proved to be cost effective. A 1980 report from the Rehabilitation Services Administration shows a long-term benefit of approximately $11 for each dollar invested in the cost of rehabilitation since 1975.

Innovative training programs are succeeding in placing people with severe disabilities in paying jobs. "Job Development and Enhanced Productivity for Severely Disabled Persons" is the title of a three and one-half year project conducted by the Job Development Laboratory at The George Washington University. Funded in part by a grant from the Rehabilitation Services Administration, the project trained and placed 79 severely disabled persons in 32 different information handling jobs. Many of the individuals placed were formerly considered unemployable by their state vocational rehabilitation agencies. Disabilities included spinal cord injury, cerebral palsy, muscular dystrophy and stroke. A follow-up study of 25 percent of the group indicated a $7 return to the economy for every $1 investment by the government after only three and one-half years. The *total* cost of placement averaged $1,827 per client while the average *yearly* contribution in federal and state taxes was $1,455.

Project Transition: from institution to employment

Project Transition, a cooperative venture of the Virginia Department of Rehabilitative Services, the Fairfax-Falls Church Community Service Board and the CETA program (Comprehensive Employment and Training Act), is just completing its first year of operation. Approximately 20 mentally retarded people have been placed in paid employment in clerical jobs, food services and housekeeping positions. Most of those already placed are considered moderately retarded and five had been institutionalized. After a brief orientation period, a person is placed on the job site with a staff member. For approximately two weeks the staff member remains on site, helps the client learn the job and advises the supervisor on how to work effectively with the new employee. Staff remain available to do follow-up in case any problems arise.

On the basis of only the first year, this project is proving to be cost effective. It costs $4,000 for each successful placement—considerably less than the $5,500 combined costs for maintaining a person in sheltered employment and providing Supplemental Security Income payments.

Not every severely disabled person can make the transition to gainful employment even with special training programs. A full range of choices and opportunities needs to be available so that all individuals can reach their full potential.

The goal—dignity and self-esteem

It may seem like a paradox, but to save money it's often necessary to spend it. This is particularly true when it comes to education and training programs for people with disabilities. The combined savings resulting from taxes recovered from earnings, income maintenance reductions and institutional avoidance indicate that education is a solid investment. The cost of dependency in most cases far outweighs the cost for developing independence.

We don't need to search hard to see the human advantages of direct service programs for people with disabilities. They and their families benefit psychologically, and the community as a whole is enriched by their contributions. Most important of all, disabled individuals who are able to realize their potential achieve a sense of dignity and self-esteem that transcends the cost benefits.

Dr. Edwin Martin, Assistant Secretary for Special Education and Rehabilitative Services, U.S. Department of Education, concisely summarized the cost effectiveness and human arguments for special education programs in testimony before Congress several years ago when he commented, "In providing appropriate educational services for handicapped children the Congress has one of those rare opportunities to save money by doing the right thing."

Education and rehabilitation programs are part of a process which helps individuals do what they *can* do to the fullest extent possible. Success may range from an executive level office job to employment in a sheltered workshop or the mastery of daily living skills. The ultimate goal is improvement in the quality of a person's life. This has no price tag.

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*These entries are part of ERIC, an information system operated by the National Institute of Education. Documents contained in the system are assigned an "ED" number and are stored on microfiche in over 630 locations in the United States. "The Directory of ERIC Microfiche Collections" may be obtained by writing to: ERIC Processing and Reference Facility, 4833 Rugby Ave., Suite 303, Bethesda, MD 20014.

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Statement of Child Development Resources, Lightfoot, Va.

Child Development Resources (CDR) has had six years of experience as a grant recipient under the Handicapped Children's Early Education Program (HCEEP). For three years (1975-78), we were funded as a Model Demonstration Project, and for three years (1978-81), we have been funded as an Outreach Project. It is because of this experience that the Board of Directors of CDR urges strongly the continuation of federal funding of HCEEP at its present level plus inflationary allowances and maintenance of HCEEP as a categorical program of the Office of Special Education.

I should like to emphasize that the Board of Directors of CDR is made up of 25 persons whose political affiliations are not a concern of membership. All of us are committed to the achievement of the national goal, adopted by Congress, to provide programs for the handicapped which will allow each individual to achieve his greatest potential. We believe that this can best be done through a national program, of which HCEEP is a part, rather than through 50 separate state programs.

We call your attention to the following facts:

--HCEEP encourages programs which result each year in increasing the number of handicapped children served.

--The education which these children receive increases their rate of development, makes them as independent as possible, and thus decreases the need for high-cost, life-time institutional care or life-time dependence. Without early intervention, the handicapped child grows into the handicapped adult, with the level of handicap possibly increasing.

--HCEEP is cost-effective not only in purpose, but also in method. It is a nationwide competitive program with peer review. It supports those agencies which, in the eyes of professionals across the country, are particularly likely to improve and expand early childhood education for the handicapped at a reasonable cost.

--Because of its competitive basis, HCEEP encourages the development of superior programs of proven quality across the country. Quality, of course, relates to cost-effectiveness - a little money unnecessarily badly spent is wasted.

--In contrast, block grants to the states which include these funds for early education of the handicapped will not, uniformly, produce the same level of excellence. In short, there is a loss of quality control at the federal level when block grants are used.

--Federal funding to distinct programs, as opposed to block grants to the states, also makes possible the coordination of programs for the handicapped. It assures that Wyoming, for example, is not spending money in 1982 to develop a program that Virginia discovered was not viable in 1979. A great deal of time, effort, and money is lost when each state operates independently. If we are interested in economy, coordination is of critical importance.

--HCEEP's requirement that each agency funded actively seeks the continuation of its funding through non-federal money directly encourages the fulfillment of the adopted national goal of providing education for the handicapped from birth to age twenty-one. Block grants, in contrast, may well result in the substitution of federal flow-through money for previously supported state functions, thus bringing us no nearer to the national goal.

May I again emphasize that the views expressed herein are those of a lay Board of Directors familiar with HCEEP over a six-year period. We are not professionals; most of us do not have handicapped children; we have no vested interest. We support HCEEP because we have seen its effectiveness, because we have seen what CDR has been able to accomplish towards furthering the education of the handicapped through HCEEP funding.

Cutting or block-granting these funds will result in less cost-effectiveness, less quality, and less early education for the handicapped child.

Thank you for this opportunity to present our views.

Your support for the Handicapped Children's Early Education Program as presently structured is urgently needed. This program has been shown to be a cost effective method of developing programs for preschool handicapped children which in turn reduce the long term costs of educating handicapped individuals.

The following information concerning cost effectiveness of preschool intervention has been excerpted from the attached report.

> *"Schweinhart (1980) presents data on the cost of operating the Perry Preschool Project in relationship to its benefits. Results of this cost-benefit research indicated that: 'the cost of operating the program (all amounts throughout are expressed in 1979 dollars) was $2,992 per year per child, a total of $5,984 for the two-year program. The benefits were (1) $668 per child from the mother's released time while the child attended preschool; (2) $3,353 per child saved by the public schools because children with preschool required fewer years of special education; and (3) $10, 798 per child in increased lifetime earnings projected from educational status. These benefits came to a total of $14,819 per child. Taken against the cost of the program operation, the benefits amounted to a 248 percent return on the original investment' (page 1)."*

Although Handicapped Children's Early Education Programs have been federally funded, they have been locally initiated and developed and designed with the potential for use in a variety of settings in other areas of the state and nation. Great emphasis has been placed on developing programs that build on local interagency cooperation offering opportunities for public and private groups to work together to maximize resources and impact. The demonstration funding cycle allows for the development of quality, cost effective programs and the Outreach funding cycle eliminates the need for reinventing the wheel each time new services are initiated in another community.

It is a major concern that these monies may be sent to states in a block grant. As we understand it, this mechanism builds in no assurance that any money would be earmarked for handicapped preschool education.

Please contact us if you would like additional information or if we could testify at appropriate hearings. It is of vital concern to families of handicapped children as well as to taxpayers who bear the brunt of long-term education and treatment that these mechanisms for development and dissemination of cost effective methods not be eliminated.

A REVIEW OF LITERATURE ON THE LONG RANGE EFFECTS OF EARLY INTERVENTION ON CHILDREN

Early Research

The effects of early intervention on children were documented as early as the 1930's, by Skeels and Dye (1939). In this landmark study, 13 children, ages seven to 30 months with an IQ range of 35 to 89, were transferred from an orphanage to an institution for the mentally handicapped where female residents, acting as surrogate mothers, provided them intense stimulation. A control group of 12 children, ages 11.9 to 21.8 months with an IQ range of 50 to 103, remained at the orphanage.

Two years later, those in the experimental group scored an average gain of 28.5 IQ points, from 64 to 92, and those in the control group scored an average loss of 26.2 IQ points. At the end of the experiment, eleven of the children in the experimental group were legally adopted. After two and one half years in their adoptive homes, this group's mean IQ went up nine points to 101. However, two children from the experimental group who were not placed in adoptive homes declined in their rate of mental growth. The children in the control group had made slight gains in IQ, but were still considered mentally retarded.

After 21 years, Skeels (1966) located all the children, now adults, and found that the two groups had maintained their differences. All 13 in the experienental group were self-supporting or functioning adequately as housewives; all but two had completed high school, with four having one or more years of college. Their median educational attainment fell at the 12th grade level. Of the control group, one had died in a state institution; one was in a mental hospital; three were in institutions for the mentally retarded; and the rest were employed. Their median education level was below the 3rd grade.

A second early study demonstrating long range effects of preschool education for mildly and moderately handicapped children was conducted by Kirk (1958). In this study, 81 mentally retarded children between the ages of three and six, with an IQ range of 45 to 89, were identified and studied over a period of from three to five years.

The children were placed in one of four groups. The Community experimental group and attended a regular preschool in the community; the institution experimental group and attended a preschool at the institution where they lived; the community contrast group and lived in the community, but did not attend a preschool; or the institution contrast group and lived in an institution, but did not attend a preschool. Kirk concluded that "children receiving preschool education in the community and institution made significantly greater changes in IQ's and SQ's (social quotient) on the Binet, Kuhlmann, and Vineland test as compared to the contrast groups." (pg. 200)

Research of Early Intervention Programs Initiated in the 1960's and Early 1970's

From this early research, as well as from a strong social commitment, a wave of early intervention programs emerged in the 1960's and early 1970's. Bronfenbrenner (1974), reviewed and analyzed follow-up data from research conducted during this period and addressed five questions of considerable scientific and social impact:

1. Do children in experimental programs continue to gain in intellectual development so long as intervention continues, or at least do they maintain the higher level achieved in the initial phase?
2. Do children continue to improve, or at least to hold their own, after termination of the program, or do they regress to lower levels of function once the program is discontinued?
3. Is development enhanced by beginning intervention at earlier ages, including the first years of life?
4. In terms of long-range impact, what kinds of programs are most effective?
5. Which children from what circumstances are most likely to benefit in the long run from early intervention?

The studies selected for this research met the following criteria.

1. systematic follow-up data for at least two years after termination of intervention;
2. similar information on a control group matched on relevant personal characteristics (e.g. age, ability) and background variable (e.g. social class, race); and
3. data comparable from one project to another.

In addition 20 research studies, meeting one or two of the above stated criteria, were used "to challenge, confirm or clarify conclusions drawn from the primary investigations." (p.3).

Of the seven projects selected, five involved intervention primarily in preschool settings; two were home based. The seven projects included: Howard University Preschool Program, Washington, D.C.; Perry Preschool Project, Ypsilanti, Michigan; Early Training Project, Nashville Tennessee; Philadelphia Project, Temple University; Indiana Project, Indiana University; Infant Education Research Project, Washington, D.C.; and Verbal Interaction Project, Miniola, New York.

The following is Bronfenbremmer's summary of the conclusions on this analysis:

Preschool Intervention in Group Setting. The results are based on twelve studies involving children ranging in age from one to six. Eight of these studies included comparisons between experimental and control groups. Conclusions regarding program effectiveness are cited only if supported by results from such comparisons.

- Children showed substantial gains in IQ and other cognitive measures during the first year of the program
- Cognitively structured curricula produced greater gains than play-oriented nursery programs
- Neither earlier entry into the program, from age one, nor a longer period of enrollment, up to five years, resulted in greater or more enduring cognitive gains

- By the first or second year after completion of the program, sometimes while it was still in operation, the children began to show a progressive decline, and by the third or fourth year of follow-up had fallen back into the problem range of the lower 90's and below.

Home Based Tutoring Programs. The results of the two studies in this area were similar to those for preschool programs in group settings. Children showed dramatic gains in IQ while the project was in operation but began to decline once the home visits were discontinued.

Parent-Child Intervention. A total of nine studies, involving children from the first year of life through elementary school, focused simultaneously on parent and child as the targets of intervention. Conclusions are again based on randomly constituted experimental and control groups.

- Parent-child intervention resulted in substantial gains in IQ which were still evident three to four years after termination of the program.

- The effects were cummulative from year to year, both during intervention and, in some instances, after the programs had ended.

- The magnitude of IQ gain was inversely related to the age at which the child entered the program, the greatest gains being made by children enrolled as one and two year olds.

- Parent intervention was of benefit not only for the target child but also for his younger siblings.

- Gains from parent intervention during the preschool years were reduced to the extent that primary responsibility for the child's development was assumed by the staff member rather than left with the parent, particularly when the child was simultaneously enrolled in a group intervention program.

- By the time the child was five years old, parent intervention appeared to have little effect so far as gains in intellectual development are concerned. But children who were involved in an intensive program of parent intervention during and, especially, prior to their enrollment in preschool or school, achieved greater and more enduring gains in the group program.

- Parent intervention influenced the attitudes and behavior of the mother not only toward the child but in relation to herself as a competent person capable of improving her own situation." (pg. 52-52)

Lazar, Hubbell, Murray, Rosche, and Royce (1977) summarized the findings of fourteen longitudinal studies of low-income children who participated in experimental infant and preschool programs during the 1960's and early 1970's. Lazar states, "that the findings in this report now leave no reasonable doubt that, in the main, programs which had deliberate cognitive curricula had a significant long-term effect on school performance. The findings are both too conservative in the methods of data analysis from which they emerge and too dramatic in their consistency and size, for the main effects they found to be spurious. The demonstration that investments in early education have long-term benefits that are both humane and fiscal cannot help but quell the doubts that have effectively frozen such investments for almost a decade." (pg. 2)

Specifically, the analysis resulted in the following conclusions: .

- "Infant and preschool services improve the ability of low-income children to meet the minimal requirements of the schools they enter. This effect can be manifested in either a reduced probability of being assigned to special education classes or a reduced probability of being held back in grade. Either reduction constitutes a substantial cost reduction for the school system.
- Low income adolescents who received early education rate their competence in school higher than comparable adolescents who did not have preschool education.
- As measured by the Standford-Binet and the WISC tests preschool programs produce a significant increase in the intellectual functioning of low-income children at least during the critical years of the primary grades in school." (pg. 27)

Recent Research. Recent data on the long term effects of preschool education on disadvantaged children is provided by Schweinhart and Weikart, (1978). The study was conducted at the Ypsilanti Perry Preschool Project, a program begun by Weikart and his associates in 1962. They present nine year follow-up data on: academic aptitude; achievement over time; classroom behavior; grade placement; and economic costs and benefits.

Academic Aptitude. "Before preschool, the groups were virtually identical in IQ. Children who attended preschool experienced a gain in IQ of 15 points while they werein preschool, almost all of it during the first year. Meanwhile, the chilren who did not attend preschool had an IQ increase of four points, which probably represents the extent of the artifact of statistical regression to the population mean for these groups. Hence there was a group difference of 12 points at the end of preschool. A year after preschool, the difference had decreased to five points, partly because of an IQ decrease among preschool children and partly because of an IQ increase by children without preschool as they completed kindergarten. This difference remained through first grade, during which time both groups rose slightly in IQ. By the end of the third grade, there was no longer a difference between groups, and no difference of consequent appeared thereafter. (pg. 9).

Achievement. Based on the California Achievement Test (CAT) results, "the group difference favoring preschool, instead of becoming smaller during the school years, became increasingly greater. By eighth grade the group difference reached a grade equivalent of more than one year. At eighth grade for the first time, children with preschool had significantly higher scores on all three of the major divisions of the CAT; reading, language and arithmetic. It appears that the children who attended preschool made greater use of their academic potential than those who did not attend preschool." (pg. 9)

Classroom Behavior. "The classroom behavior of children who attended preschool was consistently rated more highly by teachers in kindergarten, first grade, second grade, and third grade. Differences were slight, but they persisted over the four years of assessment." (pg. 10)

Grade Placement. "Children who attended preschool were found to be more successful in school as measured by the school's own criteria of success. Children's grade placement at fourth grade was determined to be either regular placement on grade in regular classrooms or special placement through repetition of one or more grades or through placement in a special education program.

By grade four, 38% of children without preschool received special placement, while this was the case for only 17% of children with preschool, a significant difference. Preschool experience cut the rate of special placement in half." (pg. 11)

Schweinhart (1980) presents data on the cost of operating the Perry Preschool Project in relationship to its benefits. Results of this cost-benefit research indicated that: "the cost of operating the program (all amounts throughout are expressed in 1979 dollars) was $2,992 per year per child, a total of $5,984 for the two-year program. The beneifts were: (1) $668 per child from the mother's released time while the child attended preschool; (2) $3,353 per child saved by the public schools because children with preschool required fewer years of special education; and (3) $10,798 per child in increased lifetime earnings projected from educational status. These benefits came to a total of $14,819 per child. Taken against the cost of program operation, the benefits amounted to a 248 percent return on the original investment" (pg. 1).

Fredericks, Moore, and Baldwin (1980) examined the long range effects of early childhood education on a TMR population. The first question they addressed was "to what extent are the benefits of a preschool experience maintained one or more years following that preschool experience? (pg 5).

To answer this question an ex post facto research design was employed. "Beginning in Spring, 1975 and continuing through to the present time, all preschool and school age children in Oregon who were in trainable mentally retarded (TMR) programs funded by the Oregon Mental Health Division had been given, on a pretest-posttest basis, a criterion referenced inventory of skill development. That instrument, the Student Progress Record (SPR), is composed of 13 subtests: receptive language, expressive language, motor skills, social skills, reading, writing, number concepts, money, time, eating, dressing, personal hygiene, and physical fitness. Annual data were reported for each child in each TMR classroom in Oregon on each of th 13 subtests. Oregon, thus, had had continuous data to track TMR children across at least three successive years. Data were, thus, available for children who had recently completed a preschool experience, as well as for those who had not been enrolled in a preschool program." (pp. 7)

In 1977, a total of 1,276 children enrolled in TMR classrooms in the State of Oregon were administered the SPR. Of these 1,276, a total of 151 were included in this investigation. Of those 151 children, 68 had no preschool experience, 35 one year of preschool, and 34 two years.

The following results were reported:

Social. There were no significant differences in socialization scores between nonpreschool and preschool groups. (pg. 10)

Language. Measurement of language scores over time indicated significant differences between those with two or more years of preschool and those with no preschool. The differences in language scores were not significant between those with no preschool and those with one year of preschool. (pg. 10)

Academics. Measurement of academic skill scores over time, considering combined scores, indicate signficant differences between those with two years of preschool and those with no preschool. There were no significant differences between those with one year of preschool and those with no years of preschool. (pg. 10)

Self-Help. Measurement of self-help skills over time, considering combined scores, indicate signficant differences between those with two years of preschool and those with one or no years of preschool. There were no signficant differences between those with one year of preschool and those with no preschool. (pg. 11)

Motor. Measurement of motor skills over time, considering combined scores, indicate significant differences between those with two years of preschool and those with no preschool. The difference between those with one year of preschool and those with no years of preschool is non-significant. (pg. 11)

They conclude that: "taken collectively, the results for the five curricular areas (social, language, academic, self-help, and motor) support the contention that a preschcol expereince does influence skill development, and that the results of that preschool experience are maintained over time." (pg. 11)

The authors also point out an additional factor that emerged from this data. From a survey of eighty-eight percent of the school districts containing TMR classes, it was reported that in the past four years 131 children who were placed in TMR programs moved to EMR classes or regular classes. Of these 131 children all but 11 had at least one year of preschool expereince; 94 of the children had two or more years of preschool.

The effects of early intervention on severely handicapped children is extremely difficult to assess primarily because of a lack of instrumentation to measure the progress of this population of children. Bricker and Dow (1980) discuss this issue and present data on a 3-year model center program at the University of Miami, for severely handicapped chidlren. Fifty children (25 males and 25 females) comprised the sample population for this study. The children attended a center-based educational program that incorporated both individual and group training activities. Support staff such as physical therapists and nurse practitioners were incorporated as consultants into the daily activities. Parent involvement in the program covered three areas: educational training, social services and counseling.

Child progress was assessed by the Uniform Performance Assessment System (UPAS). UPAS produces scores in four different curriculum areas, as well as an overall score. The domains include communication, gross motor, social/self-help, and preacademic. Results show a significant improvement in each of the four domains and the overall score in terms of the percentage of items passed. Equally as important data for this population of children in their current placement. Of the 50 children two are in a residential facility, while the remaining 48 children are in their home or foster homes, attending community-based programs.

In summary, the evidence appears quite convincing that early educational intervention results in positive efforts on the lines of handicapped children and their families.

STATEMENT OF NATIONAL COUNCIL OF STATE EDUCATION AGENCY COMMUNITY EDUCATORS

The National Council of State Education Agency Community Educators is pleased to present written testimony on behalf of maintaining the $10 million funding level as passed in the 1981 Continuing Resolution for Section 804 of the Community Schools and Community Education Act of 1978 (PL 95-561, Title VIII). We are also requesting that the $10 million be sustained in the 1982 federal budget.

Through the efforts of the state education agencies, community education is expanding nationwide. Presently, fifty-one (51) state education agencies (SEAs), including D.C., have a person designated with community education responsibilities. In thirty-four (34) states, the State Community Education Director is full-time. In the United States, there are 15,799 school systems and 1,300 are designated as community education school systems with 8,000 school buildings being utilized as community schools.

In these community education school systems, community education has a direct impact on improving the economy and local communities by:

1. Employing individuals in the community.
2. Eliminating duplication of services.
3. Coordinating resources in the community.
4. Utilizing tax-supported school facilities for the good of the community.
5. Conducting training programs that make it possible for people to obtain jobs or get a better job. This is done in co-partnership with local industry in the community.
6. Providing opportunities for older citizens to become involved in their community.
7. Lowering energy cost by providing services closer to where the people live.
8. Cutting down, and in some areas eliminating, school vandalism.

A recent National Institute of Education Study found that the cost of school vandalism runs about $200 million annually and that more acts of vandalism occur during non-school hours. As a result of community education programs in the United States, vandalism to our schools in community education school systems has decreased greatly. We all know that school buildings represent one of the biggest public investments in this Country. Today in the United States, some 8,000 community schools open their doors to serve the total community, preschool through senior citizens, and assist local community members in resolving their own needs. As a result, they dramatically increase the usage of such buildings, and make public tax support of schools a much better investment.

In our Country, community education has also had an effect on decreasing high school dropouts and juvenile crime rate. This has been accomplished by getting support for youth and service organizations by the adult community members.

Five (5) state education agencies are considering or in the process of developing state community education legislation, twenty-five (25) states have passed legislation supporting community education, and thirteen (13) state education agencies are providing state funds to local education agencies for community education programs. This progress within the states has been due to federal funding for community education. These federal dollars have generated millions of state and local dollars for community education. Before the advent of federal funding there were only nine (9) state education agencies involved in community education.

Because of the federal dollars, the state education agency has been responsible for implementing community education at the local level. The federal involvement in community education has been very successful. The Community Schools Program was evaluated by Development Associates of Arlington, Virginia. This independent firm stated that the results of the evaluation were overwhelmingly positive. The Study found that:

- At the local level, the project's results included increased use of school facilities, increased interagency coordination, increased citizen participation in school and other public agency decision-making, and increased community support for schools.

These conclusions were reached as a result of interviews with randomly selected individuals directly involved in the projects.

A sampling of school principals and teachers resulted in 85 percent reporting that their buildings were open more for community use. Moreover, 77 percent stated that there were improvements in the types of cooperation and communication between their school and other agencies because of community education activities.

With regard to the impact of community education on interagency cooperation, 78 percent of the staff from community agencies said that the community school staff had facilitated an interagency network of services and 56 percent described positive changes in interagency cooperation and coordination which were attributable primarily or entirely to community education staff.

The sentiments of lay citizens were equally positive. For example, 68 percent of the chairpersons of community education advisory councils reported increased community involvement in public schools because of community education. Thus, the findings justify greater involvement by the federal government in developing community education throughout the Country.

You are to be commended for passing the Community Schools and Comprehensive Community Education Act in 1978. With the $10 million appropriation in the 1981 Continuing Resolution, the State Grant Section (Section 804) can be implemented. Although each section of the bill is important if the legislation is to fully meet its stated objectives, the most important component is Section 804: State Programs for Community Education. The National Council of State Education Agency Community Educators recommend $10,000,000 for the State Program for FY '81 and '82. Provided as Appendix A is a breakdown of the amount each state will receive if you maintain the funding at the $10,000,000 level. The authorization level for FY '81 is $123,000,000.

The role of the state education agency is critical if community education is to continue to expand in the years ahead. The states that have experienced the most successful development are those where the state education agency has taken an active role in terms of providing developmental and technical assistance. Eighty (80) percent of the funds received by the state education agency under this legislation will be allocated to local education agencies. There is little question that the states are in a much better position than the federal government to determine who should be funded. Of equal importance, the state education agency can provide more continuous and meaningful assistance to funded projects.

It has been determined that a small amount of seed money is necessary to start community education at the local level. Since 80 percent of the federal funds will go to local education agencies, this will make it possible to start community education programs. With these federal dollars school buildings can remain open, learning can take place for all ages, a major portion of school vandalism will be eliminated, interagency coordination will take place, increased citizen participation will occur, and this will result in increased community support for public education. Community education programs, once started, have an extremely high rate of continuation on local money. It is with a sense of urgency that the National Council of State Education Agency Community Educators requests that you do not cut the $10,000,000 for Section 804 of the Community Education Act. The beneficiaries of these funds will be millions of individuals of all ages involved in their public schools and the overall improvement of the local communities in which they reside.

Appendix A

BENEFITS TO STATES UNDER THE ALLOCATION FORMULA
SECTION 804 STATE PROGRAMS FOR COMMUNITY SCHOOLS
& COMPREHENSIVE COMMUNITY EDUCATION ACT OF 1978 (PL 95-561)

1981 Continuing Resolution $10,000,000 Appropriation

	State	1981 Appropriation
1.	Alabama	$162,247
2.	Alaska	$ 50,000
3.	Arizona	$103,276
4.	Arkansas	$ 94,311
5.	California	$971,134
6.	Colorado	$171,134
7.	Connecticut	$117,768
8.	Delaware	$135,612
9.	District of Columbia	$ 50,000
10.	Florida	$ 50,000
11.	Georgia	$376,938
12.	Hawaii	$220,870
13.	Idaho	$ 50,000
14.	Illinois	$ 50,000
15.	Indiana	$489,092
16.	Iowa	$234,449
17.	Kansas	$126,473
18.	Kentucky	$102,144
19.	Louisiana	$151,889
20.	Maine	$173,128
21.	Maryland	$ 50,000
22.	Massachusetts	$180,526
23.	Michigan	$251,161
24.	Minnesota	$399,569
25.	Mississippi	$175,129
26.	Missouri	$104,843
27.	Montana	$210,947
28.	Nebraska	$ 50,000
29.	Nevada	$ 68,285
30.	New Hampshire	$ 50,000
31.	New Jersey	$ 50,000
32.	New Mexico	$318,401
33.	New York	$ 52,878
34.	North Carolina	$772,328
35.	North Dakota	$242,457
36.	Ohio	$ 50,000
37.	Oklahoma	$467,070
38.	Oregon	$123,731
39.	Pennsylvania	$106,714
40.	Puerto Rico	$511,940
41.	Rhode Island	$139,486
42.	South Carolina	$ 50,000
43.	South Dakota	$126,299
44.	Tennessee	$ 50,000
45.	Texas	$188,578
46.	Utah	$567,822
47.	Vermont	$ 57,317
48.	Virginia	$ 50,000
49.	Washington	$225,309
50.	West Virginia	$165,076
51.	Wisconsin	$ 80,993
52.	Wyoming	$203,810
		$ 50,000

STATEMENT OF MICHELLE THOMAS, STUDENT, UNIVERSITY OF MINNESOTA

Mr. Chairman, Members of the Subcommittee, I would like to thank you for providing me this opportunity to submit written testimony on behalf of the thousands of minority and disadvantaged students from across the United States who have benefited from TRIO services.

My name is Michelle Thomas and I am currently a senior Political Science major at the University of Minnesota. I have spent the past three months as a TRIO intern at the United States Student Association (USSA) sponsored by the Mid-America Association of Education Opportunities Personnel Program (MAAEOP).

As a student at the University of Minnesota I have been employed by the Upward Bound program (a TRIO program) and have been a recipient of Special Services for Disadvantaged Students (SSDS).

During my high school years, I was not very concerned with furthering my education after graduation and college was the furthest thing from my mind. Lacking motivation, self-confidence and encouragement from my teachers, I failed academically. This was certainly evident each quarter when report cards were mailed home. I was eventually termed to be "an underachiever".

It was during my junior year in high school that Upward Bound was recommended to me and I applied doubting the effects if there were to be any. Because of a long waiting list, I could not enter the program. However, the story does not end here.

Despite my absence from the program I was able to receive instruction from staff members in preparation for the Scholastic Aptitude Test. Upon receipt of satisfactory scores, I was admitted to the University of Minnesota as a freshman and I became a participant in the Special Services for the Disadvantaged Students (SSDS).

As a participant in SSDS, I can affirm the fact that without this type of assistance, college studies as well as the pressures of every day college life would have been very difficult to handle. The SSDS Program staff have assisted me in career counseling, tutoring in various subjects, and they have always been more than willing to sit down and talk with me at a moments notice. With the help of the program I am proud, as are my parents, to say that in June I will graduate from the University of Minnesota with a Bachelor of Science degree from the College of Liberal Arts.

Keeping this in perspective, I want to emphasize that these types of supportive services are necessary at the pre-college level if a larger percentage of low-income students are to be provided an opportunity to achieve the upward mobility afforded by higher education.

Today only 22.4 percent of students from low-income families attend college while 58.2 percent of students from incomes above $25,575 go on to higher education.

The many special services programs a few of which I mentioned earlier, serve to improve retention of poor and minority students in college. The demand for such funding is high and the number of institutions requesting Special Services funds has increased at least 15 percent each year over the past 3 years.

The Upward Bound Programs serve to motivate and prepare poor and disadvantaged youths for college. A recent study completed by the Research Triangle Institute under contract with the Department of Education demonstrated that when compared to their counterparts who did not participate in the program, Upward Bound students:

1) entered some form of post-secondary institution at significantly higher rates.
2) were more likely to enter four-year colleges and universities.
3) remained in college proportional to the general college student.
4) expressed greater interest in furthering their education beyond undergraduate work.

Talent Search programs are particularly important in assisting minority students make the transition to college. Project placement records suggest that one third of the black college freshmen in 1978 entering college had contact with a Talent Search Office.

Finally, funding is desperately needed to continue training of TRIO staffs. This is the only program that concentrates on improving students academic skills.

Despite the Reagan Administration's promise to provide for the needy and the disadvantaged, I can only emphasize the significance and the impact that these programs have had on the lives of thousands of minority and disadvantaged students across the United States.

In conclusion, let me say that I can appreciate the difficult position this Subcommittee finds itself in attempting to satisfy those who are concerned with social programs and those who cry for a balanced budget. I must admit though, I am rooting for the social programs.

Thank you for your time.

STATEMENT OF DAVID H. FLORIO, GOVERNMENTAL AND PROFESSIONAL LIAISON, AMERICAN EDUCATIONAL RESEARCH ASSOCIATION

Schools and colleges are focusing on quality improvement after the barrage of media criticism and a decline in fiscal support. At the same time, however, they have undergone a decade of competing demands by diverse constituencies and pressure to adopt simplistic notions of teaching and learning. THE NATIONAL INSTITUTE OF EDUCATION (NIE) is one federal agency, during this troubled time, that has anticipated the concern for quality and focused its PRIORITIES ON IMPROVING LITERACY AND DEVELOPING LOCAL CAPACITIES TO ADVANCE ACADEMIC LEARNING. Through a balance of fundamental and applied research and development, NIE's investments have produced rational evidence and specific efforts to assist state and local educators.

The nation and the new administration demand leadership from state and local educators to meet the learning challenges of the 1980's. NOW IS THE TIME WHEN THE KNOWLEDGE BASE FOR ADVANCING EDUCATIONAL QUALITY MUST BE PRESERVED AND STRENGTHENED. We need to build the fiscal support for the NIE to its FY79 funding level, $83 million; however, we recognize the need for general budget austerity and request that the Institute be funded at its current, FY81 = $74 million, level in 1982.

The federal government, the principal sponsor of educational R&D, invests relatively little in this critical area. Less than ½% of the total cost of American Education is spent on research, development and evaluation. NIE's appropriation amounts to 0.5% of the Education Department budget and all research and evaluation in ED amount to less than $135 million, 0.9% of the ED total. This is compared to 6% of federal health funds, 3% in agriculture, and 2% in transportation.(even more in other agencies (e.g., energy (45%) and defense (10%)).

These modest investments in educational inquiry have significant pay-off and promising work is underway to assist educational efforts in the years ahead. A summary of recent educational research accomplishments is attached. In brief, we have greatly increased our ability to:

--identify and share characteristics of effective schools and teaching in the primary grades (reflected in the increased test scores at those levels)
--identify learning problems in reading comprehension and math problem-solving (focusing attention the middle years when achievement declines begin and avoiding a limited concentration on rote learning for these more complex tasks -- promising work is underway in these areas)
--translate research findings into usable forms and improvement efforts to assist local educators
--focus on learning time as an essential resource which can be significantly increased in classrooms (e.g., the development of programs to assure mastery of subject matter when instruction is adapted to individual learners and curriculum content)
--identify the school-site as the location where practical wisdom and research evidence can be combined for academic improvement
--assist higher education institutions with management and financial concerns
--provide state legislators and education leaders with technical assistance in designing school finance reforms.

The drastic reduction in the budget request for NIE would blunt these productive results and severely cut back or curtail much of the potential benefits from funded projects or planned research competitions, for example:

--improve secondary schools (with a focus on jr. and sr. high schools)
--efforts to understand the specific concerns of urban and rural schools (particularly in low-income areas or those that have high concentrations of unemployed youth)
--improve instruction in written composition and the application of acquired knowledge (e.g., math and science education)
--assisting educational institutions to advance instruction for students with limited English language skills (e.g., new immigrants and others)
--advance the rational use of new learning and information technologies (e.g., mini-computers, calculators, video tape and disc, satellite and cable television as supplements to school learning in this labor-intensive field)
--improve the quality of achievement tests and other assessment tools and advance their diagnostic and instructional uses (not just as sorting devices)
--providing local, state, and national policy makers with timely, understandable reports on policy choices and their alternatives.

To retain a viable program of educational research, development, and evaluation, NIE and other programs in the Education Department (ED) must retain their present modest levels of funding, e.g., Education of the Handicapped Innovation and Development ($20 million) and special studies ($2.3 million); bilingual education evaluation and study ($6 million); vocational education Programs of National Significance ($10 million); and ESEA Title I evaluation and studies ($10 million).

Without such support, educators and policymakers across the nation will be forced to cope with severe challenges with less than available knowledge or from incomplete or obsolete information. This is particularly true in the teaching of mathematics and science. The aministration proposed to eliminate the National Science Foundation's science education program (including $15 million in math and science education R&D). This short-sighted proposal would force the Education Department to assume such inquiry (an unlikely prospect if NIE and other ED R&D budget requests are sustained by the Congress).

There has been a dramatic improvement in the quality and productivity of the educational research enterprise. Researchers are focusing on school and classroom settings, working directly with teachers and administrators to identify research problems and design improvement efforts, and focusing on the information needs of legislators and other education policy makers. EDUCATIONAL R&D IS THE LEAST INTRUSIVE WAY THAT THE FEDERAL GOVERNMENT CAN SUPPORT QUALITY IMPROVEMENT AT THE LOCAL LEVEL. The 1980's present serious concerns and problems for local school and college personnel. Please help sustain productive efforts to improve education from a sound, rational base of understanding.

The administration, in its budget statement, implies that NIE should focus on improvement efforts. They have the misperception, however, that fundamental inquiry is a separate activity which can be "delayed" or "stretched out." Fundamental and applied studies work together, one nurtures the other. Basic research provides the base for improvement developments and applied studies assist researchers in the identification of problems and issues in need of more systematic inquiry.

Pick the roots and the flower will die.

American Educational
Research Association

CONTRIBUTION OF EDUCATIONAL RESEARCH

A Summary of Recent Contributions from Educational Research & Related Activities
(basic and applied research, development, dissemination, and evaluation--RDDE)

David H. Florio, AERA

Major gains have been made in the field of educational research over the past decade. These achievements have been built on past discoveries and from significant improvements in the conduct of research activities, e.g., 1) better methods and understanding of critical problems, 2) integration of methods across disciplines, 3) efforts to integrate, translate and deliver findings in usable forms, 4) attention to socio-political, economic, and cultural forces affecting instruction and educational institutions, 5) the increased focus on realistic settings, and identification of exemplary practice, and 6) a more central concern with factors which lend themselves to purposeful change.

Many of the following examples have enjoyed important financial support from the National Institute of Education, the lead federal agency with the statutory responsibility to fund educational RDDE. Other Department of Education R&D programs and the National Science Foundation have also made contributions and collaborated with NIE in several instances.

NOTE: These selected examples represent, in most cases, the results of many research projects conducted in various settings and by several scholars across the nation. Research contributes to practice through the accumulation of evidence over time and works its way into the thinking of educators, policymakers, and interested publics. This is an ongoing process which continues in new areas of discovery and the refinement of productive achievements.

TEACHING & LEARNING RESEARCH

IDENTIFICATION OF EFFECTIVE TEACHING

The focus on time as a critical resource has allowed for the development of a general theory of basic instruction. Building on early classroom observation studies like the "Beginning Teacher Study," the Institute for Research on Teaching, and other projects, we have identified general components of effective primary teaching in the basic skills of reading and math. Direct/interactive instruction involving a focus on academic tasks, extensive coverage of content, highly structured questions designed to gain a high degree of correct answers, immediate praise for correct academic answers (and exploration of incorrect answers), whole class or small group instruction (as opposed to one-on-one), and close monitoring of performance with individualized feedback on performance are common characteristics of effective primary teaching. (Berliner & Rosenshine 1976, Brophy 1979, NIE 1980)

Practical effects. These studies and results have been primarily associated with fundamental skill development in the lower grades. Not only have we identified time as the essential resource, but we have been able to demonstrate its use and waste in a variety of settings. Here, research studies can have direct benefits to teachers participating in our studies, e.g., charting the way time is used (effectively and ineffectively) and suggestions as to improve the focus of learning resources. Initial work on time and instruction is also taking place in the secondary schools (Stallings 1980).

Research Works its Way into Effective Practice. Most research contributions to educational practice are evolutionary. That is, evidence from research is used to conduct further studies, develop programs, and shape the thinking of practitioners. One of the most significant contributions of recent educational research is the identification of differences in student learning styles and instructional needs based on past experience, level of achievement, and subject being learned. These individual differences have pointed out the futility of searching for the "effective teacher" or the "best technique." Rather, we have learned that effective teaching must be adjusted to individual student and teacher differences and the level and content of the subjects area.

A Teaching Repertoire. The fact that students are active partners in the learning process and teachers face individual differences in common learning settings has focused on the need to develop a repertoire of instructional styles, materials, and management strategies. Effective teachers, rather than transmitters of material, are seen as orchestra conductors drawing upon different instruments, talents, and techniques to reach desired outcomes. In this manner, both the child and teacher are seen as a vital resource for advancing the learning process.

Mastery Learning. The Sunday New York Times (Fiske 3/30/80) front page story, "New Teaching Method Produces Impressive Gains," extolled the benefits of "mastery learning" as a technique effectively used in low-income, inner-city schools. Mastery learning is an exemplary case of the use of research in the development of effective educational practice. It is based on the early work of Carroll (1963) on learning and individual differences, the later development and testing of the mastery learning concept (Bloom 1968 and 1976) and recent broadscale uses of the concept in different areas of the nation. The mastery concept is based on the assumption that nearly all learners can master the subject matter in question, provided that adequate time, instruction (geared to their learning style), and material (adjusted to individual level) are included. Rather than classifying students into good and poor learners, mastery learning seeks to identify (diagnose through testing) the different rates at which students learn different subjects at different levels.

COMMON CHARACTERISTICS OF EFFECTIVE SCHOOLS

The research community, through the support of NIE, has been focusing on the identification of schools which are producing substantial student achievement in difficult circumstances (Edmonds 1979). Although this research field is less developed than the teaching effects studies, a number of general characteristics have been identified: a) strong leadership oriented to academic matters at the school-site level (administration by principal), b) school climate characterized by safe and orderly surroundings (free of discipline and vandalism problems), c) school-wide emphasis on basic academic instruction (agreement among professional staff that basic skills instruction is the primary goal of the school), d) high teacher expectations for student achievement, and e) a system for monitoring pupil performance tied to instructional objectives. (NIE "Search for Effective Schools Project," contact Michael Cohen at NIE.)

CONTRIBUTIONS OF LEARNING RESEARCH

The recent and ongoing studies of cognitive development, acquisition of math and reading skills, and the measurement of academic achievement are providing fruitful evidence for the development of improved instruction and learning practice.

Research on Reading: Diminished Debate on Code vs. Language Orientation. The teaching of reading has long been characterized by the "phonics/whole ward" debate over effective instructional practices. Fundamental research on the acquisition of reading skills and comprehension from text shows that both the simplified decoding of words and the knowledge of the subject are normal complementary processes ongoing in the learner. Current work is being undertaken on the appropriate uses of each type of instruction and identification of complex tasks where decoding may slow knowledge acquisition. Similarly, the development of diagnostic tests and further work on higher reading skills are underway. (Glaser 1980).

Math Skills and Understanding. The move to increase mathematic understanding (sometimes known as the "new math") has been criticized because some of the instruction seemed to neglect computational skills. Studies revealed that many of the "new math" programs were, in fact, not fully implemented and that the seeming dichotomy between computational skills and math understanding may be replaced with a more structured approach using the rules of math (propositions), recognition of patterns, and more explicity taught problem-solving strategies (Glaser 1980).

NIE, for example, has supported a comprehensive math program for grades one through six. This program combines the traditional pedagogy of math instruction with the more beneficial aspects of mathematical understanding and is being used by over 32,000 students.

NIE also operates a collaborative program with the National Science Foundation's science education directorate to explore the uses of micro-processors in teaching and learning. Studies on hand-held calculators, minicomputers, and other devices are underway.

Achievement/Ability Measurement. Recent research on academic achievement has been focused on the use and purposes of different types of tests. These efforts are an attempt to move beyond the narrow assessment of primary reading and math skills. We are also providing teachers and parents with a greater understanding of testing. That is, national debates over the use of norm vs. criterion referenced tests have focused on the assessment of specific skills and knowledge vs. the placement of individuals in a ranking of similar students by age or grade. Recent studies have criticized the notion that "ability tests" actually measure static probability of success. Rather, there is a need to focus our measurement tools on what can be done to improve the chances of successful academic achievement (Glaser 1980).

Stages of Development. The research on stages of development (Piaget 1952, Karplus 1964) led to a greater understanding of the unique qualities of children and their ability to learn at different stages of development. This, in turn, has led to more enriched programs of early childhood education, broader and more comprehensive training of educational personnel, the focus on the first five years of life as essential for future development; and changes in testing, diagnostic procedures, and math and science curricula modifications. Development work on the uses of technology, such as, computers for instruction (Atkinson 1974), and on television, such as, the contributions to Sesame Street (NAS 1977) have drawn upon this basic understanding of learning and child development research.

The Gifted Student. Early work on gifted students in the 1950s corrected previous misconceptions about these learners, e.g., that they were subject to mental afflictions and "early burn-out." There has been a shift in both the attitude toward and the treatment of these students in recognition of the problems of boredom and failure to provide enriched programs of instruction.

Learner as Active Participant. Learning research has, over the past generation, significantly altered our view of the student from that of a passive recipient of instruction and curricular content to an active participant in the learning process. In fact, students are seen not just as problem-solvers but as actively seeking problems to solve and events to be studied (Getzels 1978). These studies also have shifted the focus from tracking and labeling students to seeking ways to reach different students through interesting and useful instructional strategies.

RESPONDING TO NATIONAL NEEDS

CONTRIBUTIONS TO THE IDENTIFICATION OF EDUCATIONAL ISSUES AND PROBLEMS

NIE and the educational research community have been instrumental in focusing the attention of educators and policymakers on important education problems and policy issues.

Achievement Testing and Basic Skills. In 1978, NIE sponsored a major conference on testing and its implications for teaching and learning (NIE, 1979). The conference explored issues, problems, and potential benefits of various forms of testing, particularly associated with the "minimum competency" testing movement in states and localities. Results include research competitions on the uses of tests, a book on testing for parents (NIE 1979), a variety of technical assistance and dissemination efforts in the areas of testing and educational measurement. These studies have also called attention to the need for early testing, diagnosis, and remedial instruction.

Declining Enrollment. NIE has produced a significant volume on the impact of declining enrollment on schools, school districts, and educational delivery systems.

Writing. NIE has sponsored conferences and symposiums on writing instruction and achievement. The National Assessment of Educational Progress has just released a report on writing achievement (9-13-17 year olds) over the past decade (1969-79) showing that writing skills have not declined in that period. Although the report demonstrates major areas in need of improvement, national attention has been paid to the neglect of writing instruction and practice in our schools and NIE has embarked on a program of research on writing instruction. Such attention has helped to reduce the gap between black students and other populations and is focusing attention on the time allocated and engaged in writing.

Pull Out and Federal Policy. The NIE sponsored study on compensatory education (the Title I study) called attention to the instructional consequences of pulling students out of regular classrooms for compensatory education programs. This has led to more concentrated "school-wide" programs and adjustments in federal law associated with targeting federal funds on eligible students.

Science and Technology. The Department of Education and the National Science Foundation (NSF - ED 1980) have recently reported on the status of science and engineering education in the nation and the decline in general understanding of science, math, and technology among non-scientists. The report calls for a renewed focus on science and math education in the schools, science "literacy" for the population, and the development of scientists and engineers in the coming decade.

National Assessment of Educational Progress. Supported by NIE and operated by the Education Commission of the States, the NAEP provides the public, educators, and policymakers with periodic assessments of achievement in various areas of education throughout the nation. NAEP has developed assessment instruments and achievement benchmarks which can be used in individual states and localities for the identification of achievement progress and problems. NIE is developing plans for increased use of NAEP data to further analyze problems in student progress.

Progress with Evaluating Federal Programs. The Department of Education, in response to congressional requests, supported a recent review of the problems, benefits, and limitations of congressional mandates and federal agency attempts to evaluate federal programs. The report highlights the need for greater consultation among researchers, policymakers and program implementation staff, a better understanding of what can be evaluated, and the purposes of different evaluations for different audiences, e.g., members and staff in Congress, federal agency administrators and policy developers, program staff at the state and local level, and so on (see Boruch and Corday 1980).

Rural Schools. NIE commissioned a study on "Education and Rural America: A Reassessment of Conventional Wisdom," (Sher 1977) which explores, among other factors, the impact of school consolidation, unique attributes of rural and small schools, and the implications for state policy. Subsequently, the study of rural and small schools is of growing importance (Nachtigal 1980) and NIE sponsors an ERIC clearinghouse on this topic at New Mexico State University.

CONGRESSIONALLY MANDATED STUDIES & CONTRIBUTIONS TO FEDERAL POLICY.

NIE conducts nationally important studies on education policies. Over the past three years, NIE has conducted or is in the process of conducting studies mandated by the Congress, e.g.,

--a three year "Compensatory Education Study" (1978) which significantly contributed to the congressional reauthorization of ESEA Title I. This study led the education committees of the Congress to describe NIE as a "unique and solid resource which educators and educational policymakers can depend on for the study of difficult and previously unknown areas which affect learning and the education process..." (95th Congress, Report No. 95-1753).

--NIE is currently conducting a mandated study on vocational education programs and has delivered a number of preliminary papers and an interim report to Capitol Hill.

--NIE conducted the safe schools study (previously described) at the request of the Congress.

--NIE houses the congressionally mandated "School Finance Study," designed to provide Congress, state and local policymakers, and educators with the effects of federal programs and educational funding on school finance. Although the study has been severely limited in appropriated funds, information on federal programs will be available for the reauthorization of ESEA in 1983.

In addition to these mandated studies, NIE has developed congressional testimony (using available and aggregated research evidence) for hearings on basic skills, enrollment, violence in schools, youth unemployment and education problems, and other topics.

ESEA Title I. In addition to the major Title I Compensatory Education Study (NIE, see above), a body of research studies and information has been developed around this most significant elementary and secondary education program of the federal government. The Department of Education (Office of Program Evaluation, NIE, NCES) continues to analyze and develop information on a) the administration and implementation of Title I policies and programs, b) effects of Title I on state and local education agencies, and c) the initial and sustaining effects of Title I efforts. (See NACEDC, 1980)

Youth Unemployment and Education.. The Department of Labor and NIE have developed studies and relevant information on the problems associated with unemployed youth and the limited education and work skills among young people. Such efforts have led to increased understanding of CETA youth programs, the need for collaboration among education, employment, and labor sectors of the economy, and a greater understanding of the educational barriers to gaining and maintaining viable employment for youth.

Other problems. NIE, National Center for Education Statistics, the Congressional Research Service, and the General Accounting Office use a variety of research reports to provide summary data for the Congress, the administration and interested publics on a number of other important and salient policy topics:

--grants consolidation in education programs
--problems of overlapping programs and mandates in federal education programs
--finance of federal programs and the implications for local governance
--public support of private schools
--enrollment trends and student populations
--statistical profiles of secondary education
--teacher and administrator supply and demand
--higher education enrollment data and implications for non-traditional (older, part-time, returning women) students
--longitudinal studies of high school students beyond their years of schooling
--minority institutions in higher education
--noncollege postsecondary schools
--directories of education and related institutions, associations, and agencies
--impact studies on federal regulatory policy, e.g., handicapped, limited English speaking, minorities, and so on.

School Finance Research: Contributions to Federal, State, and Local Policy

One of the most productive areas of educational research in the policy area has been the examination of school finance (equity, tax policy, education costs, and resource allocation). Research on inequities in school finance based on marked differences in local revenues (Wise 1968) led to a plethora of school finance court cases (e.g., Serrano, Rodrequez) to assessments of legal and legislative remedies for finance inequity, and current work in the area of differential costs to meet the differences in location, student population, and the needs of special students. NIE has produced several volumes to explain school finance issues, tax bases, court and legislative implications for education service delivery, and so on, e.g., Plain Talk About School Finance, Tax Wealth in 50 States, "School Finance at a Glance" (annual), School Finance: A Legislators Handbook, and so on. NIE is currently sponsoring an Institute for Finance and Governance and research competitions in the areas of education finance and economics. In addition, NIE has provided assistance to nine state legislators, assisting them in reforming their school finance policies (also assists the National Conference of State Legislatures and the Education Commission of the States). Also, see the congressionally mandated school finance study above.

School Desegregation Studies

The Department of Education (including NIE) has supported a national panel on school desegregation research and has assisted in the accumulation of studies on desegregation to assist both educators and the public in understanding the implications of court, legislative, and administrative actions in desegregation. NIE also has a research competition on improving instruction in integrated settings.

School Violence and Discipline

NIE initiated the Safe Schools Study to identify the level and sources of violence and vandalism in the schools and explore ways to reduce school violence. NIE has also sponsored a conference and report, In-School Alternatives to Suspension, and supports efforts to diagnose problems leading to school disruption.

IMPROVING THE DISSEMINATION & USE OF R&D

CONTRIBUTIONS OF EDUCATIONAL ORGANIZATION AND IMPROVEMENT STUDIES

The past decade of research on educational organization and change has greatly increased our understanding of human behavior in organizations, social forces affecting educational institutions, and barriers and aids to school improvement efforts. We have, for example:

--identified the school site as the essential organizational level at which to concentrate program improvement efforts (school districts being too removed from the action and the classrooms too influenced by school-wide factors).

--developed strategies to integrate rational planning with flexible strategies to handle unanticipated events, political and economic forces, and human motivations, all of which affect change efforts.

--made clear the need to involve all relevant actors in the improvement effort and to adapt programs and products to meet the context-specific characteristics of the school setting.

--focused on the need to develop cost-effective materials and organizational demands which take into account the fiscal and human resources of the institution.

--emphasized face-to-face introduction of new or altered programs and products; the need to train and prepare personnel to use new technologies; and the need to develop strong leadership at the school-site level. (NIE 1980)

DISSEMINATION FOR EDUCATIONAL IMPROVEMENT

The Development of Local and State Improvement Capacities. These studies on the improved use of R&D for educational improvement have been instrumental in shifting the focus and strategies of improvement efforts, for example:

--Improvement-directed change efforts are most productive when local participants are significantly involved in problem identification, the search for alternative solutions, and the adaptation of programs and ideas to fit the context of the institutional setting.

--R&D support for educational improvement has emphasized the need to develop local and state capacities to use research and development, prepare personnel, and implement and sustain program ideas and products.

--The need for research brokers and translators has increased in order to effectively communicate R&D outcomes and products to institutional participants (particularly teachers and administrators).

--Change efforts cannot rely either on "bottom-up" or "top down" strategies for improving educational operations in the labor-intensive education field; rather, an integrated approach emphasizing the support of administrators and the knowledgeable participation of teachers, staff, and parents is essential.

--Strict rational planning has been replaced with "contingency" strategies consistent with the characteristics of educational organizations, e.g., facing unforeseen socio-political and economic forces, informal relationships among human resources, and the ongoing bargaining and consensus building efforts needed to implement and maintain operations.

--Studies have revealed the need to focus on the implementation and control of improvement efforts (rather than the concentration only in initiation of new ideas and programs). (NIE 1980)

NIE, for example, contributes to a variety of improvement efforts: regional laboratory support to state and local education improvement and R&D exchange efforts, Southeast and Northeast consortia of state education agencies to enhance their dissemination and use of educational R&D, grants to state agencies to improve their effective use of educational R&D, a large city superintendent's network to exchange research-based knowledge on salient urban education issues/problems, and a program of research on the use of R&D to improve school practice. NIE is also initiating a program of cooperation with research and evaluation directors in local school systems.

Translation of Research into Usable Forms. In addition to services to state policymakers and educators, NIE supports the syntheses of research findings into usable forms, for example: the Research Within Reach (NIE 1978) series (the first on reading instruction is already published and others on math are near completion), and Social and Cognitive Development in Young Children program evaluation kits have been disseminated. A system of research clearinghouses (ERIC) which produce short monographs on salient policy and educational issues is also operated by NIE.

The Exchange of Knowledge and Information. Organization and educational improvement studies have shifted the focus of dissemination strategies from the simple "one-way spread" of evidence and outcomes to the need for exchanging knowledge and information between research and developers and educational practitioners. Broker roles and institutions have been developed to assist in this exchange, which has both improved change efforts and greatly enhanced researchers' understanding of educational events and problems faced in the practical world of teaching and learning (Zaltman, et al 1977). NIE, for example, sponsors R&D projects in which researchers and practitioners collaborate on study efforts.

A CONTINUING NATIONAL RESOURCE

This has been an attempt to provide educators and policymakers with a brief summary of educational research and related (RDDE) contributions. It should be seen as a continuing story to be revised and extended as our work is improved and extended. Of necessity, there are errors of omission. Further iterations of this summary will draw upon achievements in additional fields of educational inquiry and will include further examples of the way in which educational inquiry is working to improve education policy and practice.

ASSOCIATIONS AND ORGANIZATIONS IN SUPPORT OF THE FY82 APPROPRIATION FOR THE NATIONAL INSTITUTE OF EDUCATION

Research & Development Programs, Department of Education
Presented to
THE APPROPRIATIONS COMMITTEES OF THE UNITED STATES CONGRESS
Labor, HHS, Education Subcommittees

Our associations, representing literally millions of educators, researchers, and educational consumers, join in requesting your support for the National Institute of Education's appropriation for FY82. The Administration's budget request would slash 18% from current FY81 NIE funds and create a loss of 27% in spending power (accounting for inflation, using the Administration's estimate).

NIE is not a case of profligate spending. There has been no growth in its appropriation since FY79. NIE's current operating budget is at the rescinded level of $74 million, $9 million below the FY79 appropriation. NIE IS, THEREFORE, ALREADY OPERATING 13% BELOW ITS FY80 CURRENT POLICY LEVEL (accounting for inflation); 27% BELOW THE FY79 CURRENT POLICY LEVEL (if funding had kept pace with inflation).

Any further reductions would greatly damage the federal responsibility in support of educational R&D. Unlike funding for educational operations, federal funding is the principal source of all educational research support. Our request for level funding in FY82 (at the $74.1 million level) is both reasonable and reflects a willingness to equitably share in the general budgetary austerity.

NIE R&D PROGRAMS

FY79	FY80	FY81	FY82 Jan.	FY82 March	Recommended Minimum Request
$83.1m	$74.114m (rescinded fr. $77.114m)	$74.114m (loss $5m supplement)	$83.985m	$61m	$74.114m

Unless this current level is retained in FY82, the following efforts will be greatly cut back or curtailed:

- -- identifying and sharing with educators characteristics of effective schools and teaching
- -- efforts to improve instruction in reading, writing, math computation and problem solving, and for students with limited English skills
- -- improving urban education (reading and the use of R&D)
- -- improving the ability of students to use acquired knowledge (thinking)
- -- expanded efforts to improve secondary schools (jr. & sr. high schools)
- -- management and finance studies in postsecondary education to assist higher education institutions to cope with decline in fiscal resources
- -- school finance and policy studies designed to assist state and local governments (esp. diversity in costs, organizational improvement, and management)
- -- work with NSF and other agencies on math and science instruction and efforts to improve literacy among urban and rural youth and young adults (e.g., focus on areas of high youth unemployment)
- -- new efforts to assist educators in the use of information and learning technologies

NIE, in spite of its current budget constraint, has been remarkably productive. The Institute has provided the Congress with vital policy-relevant information, assisted state legislators in making policy and finance reforms, developed instructional programs in reading and math for primary skills, and identified effective teaching characteristics for the early grades. Promising work is underway in advanced learning (at the secondary level), policy studies and educational cost analysis, postsecondary education, and the use of R&D for educational improvement. **Please** help this productive effort to continue in the 1980's.

RELATED AGENCIES

STATEMENT OF NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT

Mr. Chairman, we appreciate the opportunity to appear before the subcommittee. The National Congress for Community Economic Development, is a private organization that provides information and research on community-based economic development. We are requesting for fiscal year 1982, $48.5 million for the Community Economic Development Program authorized under Title VII of the Economic Opportunity Act of 1964 as amended. This is the same amount appropriated by Congress for fiscal year 1981. The amount we request represents in effect a reduction of over ten percent when inflation is considered.

Our request consists of the following basic elements (which are similar to last year). They are:

- Part A - $44.5 million for community development corporations. As a part of this total, $19,5 million is needed for CDC administration funding, and $25 million is needed for business investments through the competitive investment fund which the Community Services Administration started in 1978.
- Part B - $4 million for training and technical assistance and demonstrations. Of this amount, $1.0 million is needed for training and technical assistance, and $3 million is needed for innovative demonstration projects in areas such as linking community economic development and job creation.

CDCs And Their Activities

Mr. Chairman, as you know, there are 37 CDCs funded under this appropriation. A list of these CDCs are attached as Appendix A. CDCs are private enterprise development corporations working in conjunction with private business and low-income communities. CDCs take a comprehensive approach to economic development that benefits the low-income residents of their communities. Their community base ensures that CDCs address grassroots needs, and that the benefits reach those who need them. Their comprehensive approach allows CDCs to coordinate different actitivites, such as small business expansion and employment training, making both activities more effective in meeting long-term needs.

CDCs provide the missing resources that prevent private sector market forces from bringing jobs and facilities to poor areas. What CDCs do depends on what their communities need.

CDC goals often include increasing job skills and income for community residents and improving housing and community facilities. To accomplish these goals, CDCs often:

- Formulate comprehensive development strategies;
- Develop and market industrial sites;
- Make equity investments in small, growing businesses;
- Provide management, financial packaging, and other forms of technical assistance to small businesses;
- Operate revolving loan or loan guarantee funds for small businesses;
- Rehabilitate, construct, and manage housing;
- Develop and rehabilitate commercial facilities; and
- Operate employment training and placement programs.

CDCs have been involved in business ventures providing goods and services such as electronic security devices, stereo parts, recording facilities, tent company, shoe company, furniture, magnetic tapeheads, life jackets, aquariums, stuffed toys, cement blocks, plastic molds, and several food processing companies.

The following are examples of the ways in which CDCs operate and leverage funds:

- The Northern Community Investment Corporation (NCIC) serves a six county area in northern Vermont and New Hampshire. One of NCIC's projects illustrates how CDCs use a combination of public and private resources to generate investment and jobs. Lisbon, NH, is a small town dependent on the shoe industry. Much of this industry, however, was controlled by national firms that have closed their operations, leaving the town in economic depression. Working with the management team from one of the shoe companies that had left the Lisbon area, NCIC drafted a financial investment to open a new company. The management team invested $330,000, NCIC invested $800,000 in equity and debt capital from a Community Services Administration grant, and banks have loaned $1.8 million. NCIC was also able to arrange loan guarantees from the Small Business Administration and the Farmers Home Administration to back parts of the package. The firm now employs 170 and has become profitable after only one year.

- Union Sarah Economic Development Corporation (USEDC), a CDC located in St. Louis was involved in the acquisition, rennovation and leasing of a historic building in the central west end of St. Louis. The building was vacant, and it had over 147,000 square feet of space for office and commercial uses. USEDC using $750,000 of Community Services Administration (CSA) funds was able to leverage an additional $2,750,000 from the Economic Development Administration (EDA) to be used in the purchase and rennovation of the structure. USEDC retained the services of a professional leasing firm in June of 1980 and as of this March, 1981, 72 percent of the building's space has been leased. Among the tenants now occupying the building are a bank, an accounting firm, a legal aid firm, a U.S. postal office, and a Government Services Administration (GSA) office, all of which hold 10 to 15 year leases.

- The Bedford Stuyvesant Restoration Corporation (BSRC) serves the largest black community in New York. Over half of the 350,000 residents of the community subsist below the federal poverty line. The CDC has invested in and assisted ventures to create and save over 3,300 jobs. As an example, BSRC was able to convince IBM to open a branch plant in Bedford-Stuyvesant and identify an unused building for conversion. After the plant proved profitable, IBM decided to build its own facility in the community, but needed a clear site. BSRC learned that a school planned for vacant property would not be built because of declining enrollments. The CDC explained the situation to the community and generated support to use the land for IBM's new plant. This plant now employs 400 people of whom 85% are black and 70% are community residents. Absentee rates are comparable with other IBM plants.

. Impact Seven Inc. serves a six county rural area in northwestern Wisconsin characterized by lack of jobs and basic development insitutions. Impact Seven invested $120,000 in subordinated debentures with two entrepreneurs, who each invested over $200,000 to establish the Franklin Signal Company, a manufacturer of electronic security devices. Impact Seven also received a grant of $400,000 from the Community Services Administration to construct the building for Franklin Signal. Franklin Signal, which started in April 1977, currently employs 110 individuals and had 1980 sales in excess of $3,870,000. They have developed a nationwide market. They are also gradually purchasing the building from Impact Seven.

. The Mexican American Unity Council (MAUC), a CDC in San Antonio and the Hyatt hotel in San Antonio, immediately adjacent to its target area. MAUC has identified minority contractors and vendors to work in the construction of a new Hyatt hotel. They have also arranged for minority/small retailers to get at least 50% of the hotel's 30,000 square feet of retail space. MAUC is working to get target (Special Impact Area) area residents jobs on the construction site at an agreed to level of 57%. The CDC received a grant from the Community Services Administration to own ten percent of the hotel.

. The Seminole Employment and Economic Development Corporation (SEEDCO) of Sanford, Florida serves low-income blacks and whites in a semi-rural county in Florida. SEEDCO and several entrepreneurs have started the International Aeromarine Corporation(IAC), one of only two amphibious airplane manufacturers in the U.S. SEEDCO utilized a $600,000 grant from the Community Services Administration to start the company. The entrepreneurs invested a $150,000 of their own funds to start IAC. IAC also received a $600,000 loan from the Community Services Administration for research and design. IAC currently employs 25 individuals and is shifting from designing to manufacturing the planes. Within a year, IAC will employ 100 individuals. They already have orders for 32 planes, which represents the first two years of their manufacturing capabilities.

Mr. Chairman, as noted earlier, this request is made under the Economic Opportunity Act. We do so at this time because continuation of that authority would be clearly our preference. We realize that continued authorization is by no means clear because the Reagan Administration has indicated its intention to cut funding for the Community Services Administration and to distribute funding in block grants for a number of activities previously authorized under the Economic Opportunity Act. These issues will be considered subsequently by the committee and by the authorizing committees.

However, we are stressing that continued direct federal funding for CDCs is essential not only for the continuation of community economic development in economically distressed areas, but as a significant tool for implementing the Administration's economic recovery plan. We feel that some of the more compelling reasons are:

- CDCs work directly with the business community inducing business participation and financing;
- CDCs are capable of leveraging sums of private, as well as, public financing for comprehensive economic development projects;
- CDCs could be a major vehicle through which urban and rural job enterprise zones are implemented;
- CDCs are the most effective means for job creation in the private sector in distressed communities;
- CDCs enhance the skill level of low-income individuals for private sector jobs;
- CDCs can help substantially in addressing youth unemployment programs by hiring youth to work for CDCs and by providing training which enables them to obtain full-time employment in businesses created and assisted by CDCs;
- CDCs create and assist small businesses, the main source of new jobs.

Mr. Chairman, for these reasons we respectfully request that appropriations be maintained at the levels indicated. We are attaching a paper (as Appendix B) prepared for the transition team which discusses further the contributions CDCs could make to the emerging policies of the Administration.

APPENDIX A

URBAN COMMUNITY DEVELOPMENT CORPORATIONS

1. Anacostia Economic Development Corporation
Washington, D.C. 20020

2. Bedford-Stuyvesant Restoration Corporation
Brooklyn, NY 11216

3. Bronx Venture Corporation
Bronx, NY 10455

4. B.P.U.M. Special Impact Corporation
Camden, NJ 08102

5. Chicanos Por La Causa
Phoenix, AZ 05034

6. Chinese Economic Development Council
Boston, MA 02111

7. Community Development Corporation of
Kansas City
Kansas City, MO 64127

8. Community Equity Investment, Inc.
Pensacola, FL 32575

9. Denver Community Development
Corporation
Denver, CO 80211

10. East Boston Community Development
Corporation
Boston, MA 02128

11. East Los Angeles Community Union
Los Angeles, CA 90022

12. Eastside Community Investment, Inc.
Indianapolis, IN 46201

13. Greater Roxbury Development
Corporation
Boston, MA 02119

14. Harlem Commonwealth Council
New York, NY 10027

15. Hough Area Development Corporation
Cleveland, OH 44103

16. Mexican-American Unity Council
San Antonio, TX 78207

17. Milwaukee Community Development
Corporation
Milwaukee, WI 53212

18. Omaha Community Development
Corporation
Omaha, NE 68104

19. Operation Life Community
Development Corporation
Las Vegas, NV 89106

20. Pyramidwest Development Corporation
Chicago, IL 60625

21. San Juan Community Development
Corporation
San Juan, PR 00936

22. Spanish Speaking Unity Council
Oakland, CA 94601

23. Union Sarah Economic Development
Corporation
St. Louis, MO 61308

RURAL COMMUNITY DEVELOPMENT CORPORATIONS

1. Community Enterprise Development
   Corporation of Alaska
   Anchorage, AK 99503

2. Delta Foundation
   Greenville, MS 38701

3. Dineh Cooperatives, Incorporated
   Chinle, AZ 86503

4. Impact Seven, Incorporated
   Turtle Lake, WI 54889

5. Kentucky Highlands Investment
   Corporation
   London, KY 40741

6. Lokahi-Pacific Corporation
   Kihei, Maui, HI 96753

7. Lummi Indian Tribal Enterprises
   Marietta, WA 98268

8. Midwest Minnesota Community
   Development Corporation
   Detroit Lakes, MN 56501

9. Natchitoches Economic Development
   Corporation
   Natchitoches, LA 71457

10. Northern Community Investment
    Corporation
    St. Johnsbury, VT 05819

11. Seminole Employment and Economic
    Development Corporation
    Sanford, FL 32771

12. Southwest Virginia Community
    Development Fund
    Roanoke, VA 24016
    (Note: Operates Urban programs in the City of
    Roanoke)

13. Tenco Developments, Inc.
    Snelbyville, TN 37160

14. Tri-Island Economic Development
    Corporation
    St. Thomas, U.S. VI 00801

OTHER PROGRAMS

1. Central Coast Counties Development
   Corporation
   Salinas, CA 93906

2. Coastal Enterprises, Inc.
   Bath, ME 04530

3. Southern Cooperative Development
Fund
Lafayette, LA 70501

4. The National Rural Development
and Finance Corporation
Washington, D.C. 20036

APPENDIX B

Community Based Economic Development: Stimulating Investment in Distressed Communities

FOREWORD

The following paper was drafted by an ad hoc committee organized by the National Congress for Community Economic Development, a national coalition of community-based development corporations. The committee members have a broad range of experience in economic development in low-income communities from both the national and local perspectives. This paper reflects the views of the committee members, not necessarily their organizations. The committee would be glad to respond to requests for additional information. Robert Zdenek will serve as the committee's contact person. He may be reached at 2025 I Street, NW, Suite 901, Washington, D.C. 20006 (202) 659-8411. Following is a list of committee members.

Steven Davidson, Policy Project on Development Finance, Washington

Van Diamond, Alu Like, Inc., Honolulu, HI

Bill DuBose, Coastal Plains Development Corp., Sullivans Island, SC

Leo Fishman, National Economic Development and Law Center, Washington

Robert Friedman, Corporation for Enterprise Development, Washington

David Kirker, Northern Community Investment Corp., St. Johnsbury, VT

Philip LoPresti, Consultant, Sterling, VA

Alfredo Navarro, Consultant, McLean, VA

Thomas Rhodenbaugh, Institute for Economic Development, Washington

Phyllis Schieffer, Impact Seven, Inc., Turtle Lake, WI

Fred Steele, Consultant, Roanoke, VA

Marcus Weiss, Attorney, Boston, MA

Robert Zdenek, National Congress for Community Economic Development, Washington

INTRODUCTION

President-elect Reagan has articulated a series of policy goals with implications for federal programs designed to address the economic development needs of low-income communities. Community development corporations (CDCs) embody many of the principles that the President-elect has expressed, and they can play important roles in helping to implement these policies.

The new Reagan administration will inherit a maze of grant, loan and loan guarantee programs that affect the development of distressed local economies. These may be classified generally as:

- Public works assistance that provides the basic physical infrastructure (water and sewer service, industrial site preparation, etc.) that is needed before private enterprise can locate in areas.
- Business investment assistance that provides access to capital, or reduces its cost, to help private businesses.
- Employment development assistance that increases jobs and employment skills.
- Technical assistance to private (usually small) firms in management and project preparation, and to local government and locally-based non-profit institutions in these skills as well as in planning and institutional development.

Federal program resources for these local development efforts total over five billion in FY 1980.

In his election eve address, President-elect Reagan called for:

> an era that will reorder the relationship between citizen and government, that will make goverment again responsive to people, that will revitalize the values of family, work, and neighborhood and that will restore our private and independent social institutions. These institutions always have served as both buffer and bridge between the individual and the state--and these institutions, not government, are the real sources of our economic and social progress as a people.

CURRENT ECONOMIC DEVELOPMENT POLICY: AN OVERVIEW

Although federal economic development programs do exist at substantial funding levels, they have not been implemented as parts of a concerted policy. As an Office of Management and Budget (OMB) study concluded less than two years ago:

> The community and local economic development problems which the United States confronts today are not being resolved through general economic policies or outright cash transfers. An integrated development approach is needed. The current organization and structure of the Federal Government impedes rather than assists in the formulation and implementation of such a development approach.
>
> As a consequence of this fragmentation, serious problems exist in the operation of Federal development assistance programs, including:
>
> - Confusion and excessive administrative burden and cost at the State and local level;
> - Limited ability to involve the private sector in development efforts;
> - Inefficient use of Federal development personnel and resources;
> - Unnecessary rigidity in the system; lack of flexibility to respond to local needs and opportunities; inability to pool and focus limited funds effectively to implement national policy;
> - Lack of policy focus and direction;
> - Fragmentation of local planning;
> - Difficulties in comparing and evaluating the effectiveness of different approaches; and
> - Gaps and overlaps in geographic coverage.

These programs are currently administered by over six agencies or departments and under the jurisdiction of several Congressional committees.

THE COMMUNITY DEVELOPMENT CORPORATION (CDC)

A potentially important mechanism through which economic development policy can be applied to the development needs of low-income neighborhoods and rural areas is the community development corporation (CDC). CDCs are private enterprise development corporations working in conjunction with private business and low-income communities. CDCs take a comprehensive approach to economic development that benefits the low-income residents in their communities. Their community base ensures that CDCs address grassroots needs, and that the benefits reaches those who need them. Their comprehensive approach allows CDCs to coordinate different activities, such as small business expansion and employment training, making both activities more effective in meeting long-term needs.

CDCs provide the missing resources that prevent private sector market forces from bringing jobs and facilities to these areas. What CDCs do depends on what their communities need. CDCs commonly help small businesses attract debt and equity capital, prepare industrial sites, train the structurally unemployed and place them in permanent private sector jobs, and build or renovate housing and commercial areas. As syndicated columnist Neal Peirce has said,

> CDCs have indeed been pioneers in combining profit-oriented business development with a control by residents of the development of their own community. The CDCs are, in a sense, the bedrock of the present day public-private phenomenon because some are now well over a decade old, they have generated millions of dollars in development, and yet all the while -- and in some places with difficulty -- they have maintained local resident control.
>
> And the CDCs, without doubt, are at the heart of old-fashioned American business activity.

CDCs have shown that economic development can be social development. The investment, jobs and housing that CDCs bring to a neighborhood gives residents a new sense of self-reliance and pride: When looting broke out in Brooklyn during a 1977 power outage, virtually the only commercial area that survived without damage was a CDC's multi-million dollar shopping center. CDC investments also pay off from a federal investment perspective too. A CDC in rural Kentucky has created 600 new jobs, half of which have taken welfare recipients off of relief roles. Forbes magazine has stated that CDC job creation "is a lot cheaper than perpetual welfare...For once, the government comes out a winner."

AN ECONOMIC DEVELOPMENT POLICY FRAMEWORK

Moreover, current federal policy still places more emphasis on programs to maintain the poor through income transfer than on those to lift low-income people out of poverty through permanent jobs in the private sector. In order to reverse this emphasis, the federal government must also shift its focus within local economic development policy from the redistribution of economic activity to its expansion, particularly in distressed communities. Congressman Jack Kemp articulated the importance of this new approach when he said, "the government's job is not to divide up prosperity and poverty. It is to encourage the first and attack the second." This is not to say that transfer payments and redistribution of economic activity are always inappropriate. Martin Anderson has observed that "As far as the American public is concerned, the overwhelming majority -- upward of 80 to 90 percent -- favor some form of government welfare programs for those who cannot care for themselves." Economic development policies that seek to affect the location of economic activity may likewise be appropriate where issues of equity are concerned. But economic development programs can also increase aggregate economic activity. As Roger Vaughan and Peter Bearse assert, "it is possible to avoid 'zero sum' redistributive programs by identifying the barriers that lead to the problems faced by the economically disadvantaged or by the residents of distressed areas." Such a strategy would help accomplish the important transition from policies that maintain the poor to those that employ them productively in the private sector economy.

President-elect Reagan stressed throughout his campaign the important role small business plays in economic development. This emphasis is entirely consistent with recent research by David Birch that shows that the birth and growth of small firms accounts for about two-thirds of new job creation. Others, including Litvak and Daniels, Vaughan and Bearse, and Kieschnick, point out that these small, job creative private enterprises face special obstacles to growth because of their size: capital access (as opposed to capital cost), management of infrequent expansion transactions (such as financial packaging and site identification/preparation), and finding and training workers. In addition, a crucial determinant of the location of job growth is unit labor costs, and most firms have difficulty identifying and screening potential workers from among the structurally unemployed.

These findings underscore the need for a highly localized implementation of development strategies. Small firms are volatile, numerous and hard to find. Employment programs must be finely attuned to their needs. (The failure to do this is one of the major weaknesses in the CETA program.) The needs of small firms will vary among communities and local strategies must be able to respond to local needs. Finally, local citizens must participate actively in setting development priorities, directing development strategies, and in reaping the benefits of development.

THE ROLE OF CDCS

CDCs have already shown a unique capacity to devise and carry out such an approach. Despite the problems of federal programs, CDCs have shown that effective coordination at the local level can increase the buying power of scarce federal dollars in this effort. For example,

- The Green Bay CDC in Wisconsin was able to redevelop the Old Fort Square, although several earlier attempts had failed. The CDC used an $85,000 state CETA grant to plan a commercial development project that will serve both neighborhood shopping needs and draw tourists to an historic marketplace. The $3.7 million project has received EDA funds, and will also attract additional private investment, train workers for entry in a local construction trade union, and create permanent jobs.
- The Northern Community Investment Corporation serves a six county area in northern Vermont and New Hampshire. One of NCIC's projects illustrates how CDCs use a combination of federal resources to generate private investment and jobs. Lisbon, NH is a small town dependent on the shoe industry. Much of this industry, however, was controlled by national firms that have closed their operations, leaving the town in economic depression. Working with the management team from one of the shoe companies that had left the Lisbon area, NCIC crafted a financial investment to open a new company. The management team invested $330,000, NCIC invested $800,000 in equity and debt capital from a Community Services Administration (CSA) grant, and banks have loaned $1.8 million. NCIC was also able to arrange loan guarantees from the Small Business Administration and the Farmers Home Administration to back parts of the package. The firm now employs 170 and has become profitable after only a year.

- The Southwest Virginia Community Development Fund in Roanoke provides a range of assistance to help small businesses expand. It can invest directly in firms, prepare financial packages for private bank loans, and develop industrial sites. SVCDF used EDA and CSA funds to develop an industrial park in its low-income community below projected cost. The park is now fully occupied, and SVCDF is expanding its industrial site program.
- The Bedford Stuyvesant Restoration Corporation serves the largest black community in New York. Over half of its 350,000 residents subsist below the federal poverty line. The CDC has invested in and assisted ventures to create and save over 3,300 jobs. As an example, BSRC was able to convince IBM to open a branch plant in Bedford-Stuyvesant and identify an unused building for conversion. After the plant proved profitable, IBM decided to build its own facility in the community, but needed a clear site. BSRC learned that a school planned for vacant property would not be build because of declining school enrollments. The CDC explained this situation to the community and generated support to use the land for IBM's new plant. This plant now employs 400, of which 85 percent are black and 70 percent community residents.
- The Cambridge Community Economic Development Corporation in Massachusetts serves a multiethnic neighborhood with a declining industrial employment base. When management was unable to keep a small furniture company open despite a strong market, CCEDC worked with a local entrepreneur, banks, the city and the state to reopen the plant. Using $55,000 in Community Development Block Grant and CETA funds, CCEDC structured a $380,000 investment, creating 35 jobs.

RECOMMENDATIONS

The Reagan Administration can take a number of steps to advance this kind of approach to development. While these recommendations are stated in broad terms, their implementation could entail a range of short and long term options. The ad hoc committee would be pleased to provide more specific suggestions. (Contact Robert Zdenek at 202/659-8411.)

1. Establish and support effective CDCs as catalysts for local job creation strategies in distressed communities. Policy should recognize that putting low-income people to work in permanent private-sector jobs is the key to a successful anti-poverty strategy and that CDCs are proven mechanisms in this effort.
2. Increase the number of effective CDCs. Not enough CDCs with the requisite sophistication currently exist for them to play this focal role nationwide. However, hundreds of incipient CDCs have already established a commitment and at least some capacity to operate effectively.
3. Increasing CDC capacity should be a high priority. Too often, federal resources are used to develop elaborate plans that are never implemented. Instead, emphasis should be placed on building local CDC technical capacity to make development happen. Such an effort could rapidly expand the number of CDCs able to coordinate local development strategies.
4. Federal resources should concentrate on encouraging the private sector, as well as state and local governments, to assist CDCs. Private corporations can help CDCs develop technical capacity and can undertake joint projects with CDCs. State and local government can involve CDCs in program planning and implementation, and target resources to CDC areas.
5. Increase CDC access to federal resources. CDCs have already shown they can deliver federal programs efficiently. This legiti-

mate role should be recognized in federal policy and program administration. CDCs could use several federal programs more effectively if access requirements were modified.

6. Support for CDCs should be part of a more effective federal economic development policy. Better coordination is needed among federal programs, agencies, and activities.

STATEMENT OF FRANK MANKIEWICZ, PRESIDENT, NATIONAL PUBLIC RADIO

We are I believe, at a critical cross-road in the future of public broadcasting. Serious questions are being asked by the Reagan Administration and by the Congress about whether we -- the nation and public broadcasting -- can continue along our current course of strong reliance by the public broadcasting system on federal support, or whether it is possible, without jeopardizing the services that have distinguished us from commercial broadcasting, for us to become more self-sufficient. I think that this process of reevaluation is a healthy one. It is forcing many of us, myself and NPR included, to examine new options for raising money and to determine with certainty our systemic priorities.

One priority has emerged clearly as imperative to the continued vigor and professionalism of public broadcasting's programming; that is, the continued insulation of public broadcasting from the political dispositions of its federal benefactors. The two year advanced appropriation mechanism which this Committee instituted in tandem with passage of the Public Broadcasting Act of 1975 has proved itself a critical element in insuring this arms length relationship. Indeed, it is a mechanism that has worked extremely well, for it has retained the integrity of annual appropriations review of public broadcasting, while at the same time it has removed broadcasting and programming functions from immediate or precipitous political review. This, I might add, has been especially valuable to an organization such as NPR which is engaged in the daily production and delivery of at least four hours of news and public affairs. Two year advanced funding has had the additional benefit of permitting advanced program planning. A capability which has made possible programs such as Morning Edition, which spanned three fiscal years in its creation, and Star Wars, which required commitments two years in advance.

As you know, the Reagan Administration has proposed a rescission of the funds for the Corporation for Public Broadcasting for FY '82 and FY '83. Approval of these rescissions would mean the end to the protections provided by the two year advanced appropriation. Although CPB's funds might still be appropriated two years in advance, once the Congress has rescinded prior appropriations, for whatever reason, the public broadcasting system will thereafter stand on uncertain footing lest rescissions be proposed as expressions of political disapproval. We therefore respectfully urge this Committee not to approve the proposed rescissions of CPB's FY'82 and '83 funds.

We find ourselves, when discussing the proposed rescissions, in the somewhat peculiar position of asserting that the principle of insulation is even more important than the level of the proposed cuts. Indeed, we would work as hard to halt cuts of even one dollar to those prior appropriations in order to preserve that principle. However, discussion of the potential effects on public radio of the $43 million and $52 million cuts, we feel, is worthwhile because it serves to illustrate the current financing and structure of the public radio system.

The Administration, in its rescission language, said that the cuts "will be primarily directed at CPB's administrative costs and national program production while CPB support for local stations will be maintained at as high a level as possible." Should such a directive be carried out, it would eliminate the entire NPR national programming schedule, and hence, the dominant portion of national programming for the public radio system. However, the Congress has vested in CPB the discretion to determine how most such allocations shall be made. CPB has asserted as well, that in this instance it retains that discretion.

Because of the economies involved in radio production and the necessity in news, in particular, to maintain a critical, central mass of personnel, the public radio system has chosen to have its national programming funds distributed in a block grant to NPR. The cost of reaggregation of funds from the stations, based on the PBS experience, would exceed $1 million -- enough money in radio to produce multiple program series. The community service grants for public radio stations, then, are designed for stations' local needs. Elimination of CPB's "national programming funds" would eliminate the sole source of funds for the entire core national programming for public radio; and without the concurrent ability, which public television stations have, for radio stations to recover funds for some of the programs.

Should, on the other hand, the rescissions be passed and CPB decide to distribute the cuts relatively evenly across public radio and public television, because of the fixed (and possibly growing) costs of copyright, satellite interconnection, and satellite debt retirement, among others, greater than a 25 percent cut would need to be absorbed by the "soft" items in the budget, primarily programming. In public radio, this would mean elimination of major segments of NPR programming; reduction in local programming, particularly in the public affairs area; and the loss from the public radio system of a substantial number of our smaller stations, more vulnerable stations. Indeed, because public radio has learned to perform on the budget margin, cuts would have a calamitous effect.

This is not to say -- and I swallow hard as I say it -- that public broadcasting should be immune from funding reductions. As I noted earlier, we are already engaged, as a result of the President's proposals, in a healthy reevaluation of our fund raising capabilities. We are looking at how new ventures might affect the viability of the system and the integrity of our service priorities.

Even without a rescission of CPB's funds, we will have to do some substantial belt tightening in fiscal years '82 and '83 because of the probable loss of funds from other federal funders of our programs -- the National Endowments for the Arts and Humanities, the National Science Foundation, and many Department of Education programs. Rescission of the funds for the Public Telecommunications Facilities Program hits very hard at public radio because of that program's emphasis on expansion of our system, a goal which we still believe is worthy. However, as a result of the success of the PTFP in its first two years, fifteen to twenty new stations a year qualify for CPB assistance. And although the 1978 Public Telecommunications Financing Act called for an increase in operational and programming support for public radio comparable to the growth in stations, CPB has told us that even at current appropriations levels, there isn't enough money to absorb the growth, so that the existing radio stations will have to divide their CSG pool into smaller grants.

We are not, then, coming to you for more money, although I believe there is a worthy and persuasive case for how that money would be used to expand the public radio system particularly in the rural areas. We could secure the stability of the stations and national and local programming services and help seed new income generating ventures. However, we are not asking that. What we would like to ask is time to take what is now an extremely successful, but still fragile, system and allow it to stand with more weight on its own feet.

Precipitous cuts will have detrimental effects on both public television and public radio. Speaking about what I know best, I can foresee a future where public radio's audiences will, where they can, increase their contributions, where corporate underwriting will also increase, and where we will have developed, with FCC approval, other, more entrepreneurial means of generating income. On the other hand, many of the avenues of raising money which may be open to public television are not viable revenue options for public radio. For example, public radio was created with the help of the Public Broadcasting Act of 1967 to enter an already active commercial radio market and to supply the programming services which listeners could not already receive. In community after community, then, public radio stations provided -- and still provide -- services to substantial audiences which, however, had not been chosen by commercial stations for carriage because they did not generate enough income. Therefore, almost by definition, a public radio station cannot expect to raise money through commericals unless it changes its format to one that is commercially attractive. Clearly, this undercuts the purpose and value of public radio. Also, because radio is used as a mobile medium, pay radio is an unlikely alternative. In FY '79 14.4 percent of total public radio system revenues came from individual listeners and 9.6 percent was from underwriters. Even if those contributions doubled, it would be insufficient to offset projected cuts in federal support, which in FY '79 made up 33.9 percent of public radio's support.

What public radio needs in order to make the transition is some time to experiment with non-traditional means of raising money, coupled with gradual reduction in funds. In FY '84, and for a few years thereafter, if the Congress decides to reauthorize the PTFP, the public radio system will still be experiencing expansion to unserved areas of the country. Existing funds will therefore be stretched among more stations, and these new stations, in particular, will need to be assisted to the point where they can establish a fund raising capability of their own. It remains our experience that the incentive to contribute to a new, or existing, public radio enterprise is greatly increased if federal support guarantees that that enterprise is secure. The leverage value of federal support in some respects exceeds the monetary value.

In summary, we believe, that NPR and the public radio system can lessen its dependence on Federal support with adequate preparation time, and with appropriations for FY '84 and beyond which take into account the particular fund raising capabilities and financial needs of the public radio system. We would like, as we believe you would, to be able to look back in five years with the same pride as we feel now, at a strong public radio service that has grown strong with federal assistance and with an increasing dose of self-reliance.

Thank you.

STATEMENT OF MICHAEL R. KELLEY, PH. D., MEMBER OF BOARD, CORPORATION FOR PUBLIC BROADCASTING

Thank you for the opportunity to address the Committee yesterday, during testimony by the Corporation for Public Broadcasting. I purposely kept my response short because time was running late, and I had not been originally scheduled to speak. I would, if possible, like to extend my remarks for the record to include the following:

"There is very little difference between the CPB Board's position which our Chair, Lillie Herndon,read to you today and my own, published in The Star. Though all of my fellow Board Members may not agree with me that there is flab in public broadcasting and that budget cuts can cause a surge of creativity, we are unanimous in urging that there be sufficient lead time before the cuts come to preserve public broadcasting's two year advance funding principle and built in opportunities for planning, and that the cuts not come wholly out of CPB's national programming efforts as OMB had initially recommended. These views in the Board's Resolution are also in my article.

CPB's national programming budget not only supports National Public Radio's fine efforts, but provides local stations -- both radio and television, large and small -- with those "big ticket" high quality programs that the stations can and do use to increase their own audiences and ultimately their local support. This kind of high quality programming is an essential part of public broadcasting's total mission.

Finally, I would like to respond to two of Senator Schmitt's earlier questions. I do think that as the appropriation for public broadcasting is cut back, we should consider reshaping the criteria for distributing those funds that pass directly through to the stations. We need to make sure that small stations serving widely scattered rural populations without a strong base of viewer support are not disproportionately hurt by the overall budget cuts. The present Community Service Grant matching formula rewards fund raising and has had general support among the stations at the recent levels of federal support. As that support is cut back we may want to include other rewards in the formula that will preserve support for the small stations which have few opportunities for raising monies in their service area.

I strongly believe that public broadcasting, particularly public television, can survive the competition from cable, videodisc, videocassette, and other new video technologies. Broadcasting has three major advantages that these other delivery systems lack: it is free, it is local, and it is portable. No other technology combines all three. As its cultural programming is taken over by cable and videocassette, however, public television will have to do some creative thinking to find a new alternative program fare that will catch the imagination and whet the appetite of the diverse, eclectic tastes of all the American people. The answer may well be continued "cultural" programming, but I think it may turn out to be something truly different and exceptional. Public television faces the need to redefine for itself and for America what it is and what its programming alternatives should be. That is both the challenge and the exciting opportunity of the 1980's."

Again, thank you Senator for the opportunity to address the Committee and to include my thoughts in the Record. I have long been and continue to be a strong supporter of public broadcasting, but being supportive doesn't also mean turning a blind eye to things that could be improved. It is this dual role that I take very seriously as a Director of the Corporation for Public Broadcasting.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF THELMA KING THIEL, VICE CHAIRMAN AND EXECUTIVE DIRECTOR, AMERICAN LIVER FOUNDATION

Mr. Chairman and Members of the Subcommittee, I would like to share a few brief comments with you. I am Thelma King Thiel, Vice Chairman and Executive Director of the American Liver Foundation who also served on the National Commission of Digestive Diseases. As a representative of the American Association for Study of Liver Diseases, the American Liver Foundation and all our chapters and affiliates, I am also speaking on behalf of thousands of victims of liver disease. Over 36,000 people have written to us in the past eight months asking for information about more than 50 liver diseases; referral to specialists; and wanting to know what research is being done to find cures for these devastating diseases.

The American Liver Foundation has been attempting to fill a tremendous void of information and research created by years of neglect in this health area.

In the area of education, the public knows little or nothing about the hundreds of functions of the liver and, more importantly, ways of preventing liver disease. At the present time, there are **no known cures for most liver diseases...yet the most serious are potentially preventable.** Education about prevention through an active, aggressive clearinghouse could help to reduce the untold human suffering and the estimated 10 billion dollar economic cost of liver disease to our country each year.

The Digestive Disease Information and Education Clearinghouse which has been established is grossly underfunded compared to other clearinghouses. The role it should be playing is vital to reducing the devastation caused by all digestive diseases. We need adequate funding of the clearing house....adequate enough to impact on this increasing problem.

In research, the recent breakthrough responsible for the development of a Hepatitis B vaccine has the potential for:

- preventing the estimated 350,000 cases of hepatitis that occur each year
- preventing the reservoir of 700,000 carriers of the disease
- dramatically reducing the incidence of cirrhosis, and
- **for the first time, preventing cancer of the liver.**

This is truly a remarkable feat.

Any cut back in funding of research at this time would not only drastically curtail current efforts, but would vastly reduce the number of young scientific investigators entering the field of research. THE ENTIRE FUTURE OF RESEARCH IN THIS COUNTRY WOULD BE ADVERSELY EFFECTED.

In addition, we recommend appropriate funding for the Advisory Board to facilitate coordination of Federal activities in digestive diseases. We urge you to consider all the recommendations made by the National Commission of Digestive Diseases, members of which agonized over the impact of these recommendations on the millions of victims of digestive diseases and on the cost effectiveness of our health care system. We **need** this investment in the health of our nation.

I thank you, Senator Schmitt, and members of the Subcommittee for considering these recommendations.

The Star-Ledger WEDNESDAY October 8, 1980

ANN LANDERS

Liver Foundation extends sincere words of thanks

Dear Ann Landers. You are a gift from heaven! In one fell swoop you have educated more people about liver disease than we could have in 10 years. In four days we have received over 6,000 letters requesting information, and we expect at least 6,000 more.

Hundreds of people who wrote said it is assumed that all liver problems are a result of drinking. Young people with hepatitis have difficulty convincing others that they don't take drugs.

We are eternally grateful for the tremendous assistance you have given us by letting people know we exist. You have given the Liver Foundation a boost that compares with the eruption of Mount St. Helens. On behalf of the board of directors — we thank you. Thelma King Theil (executive director)

Dear Thelma: I am delighted that the mention in my column produced such good results. I, too, have received a great many letters of appreciation. Here is a sample:

Dear Ann Landers: You will never know how happy I was when I read in your column the common misconceptions about liver disease.

My husband died of cirrhosis last year, and the man never touched a drop of alcohol. So many of my relatives and friends said, "I never knew George drank." When I told them, "He didn't," they looked at me as if I was a liar or a fool. No comments were made, but I knew they didn't believe me.

I clipped your column had copies made and sent them to 15 relatives and friends. Now I can hold my head up — and more important, I can vindicate George. God bless you. — Grateful in New York

For those of you who may have missed the original column, if you want to learn more about diseases of the liver and help fund research for the problems, please write for literature. The address: The Liver Foundation, 30 Sunrise Terrace, Cedar Grove, N.J. 07009. It's free and written in language anyone can understand. But do send a self-addressed, stamped envelope, please.

June 20, 1980

Ann Landers

Dear Ann Landers: Most Americans believe cirrhosis of the liver is a disease of alcoholics and hepatitis is a disease of drug addicts.

Please inform your readers that infants and children can develp cirrhosis. Everything we eat, breathe and absorb through our skin is refined in the liver. It is the most overworked and least understood of all organs.

Fifty thousand people die every year from liver disease. Half of hepatitis cases are among children and teenagers.

The American Liver Foundation is mounting a campaign to help prevent liver diseases. This is the fourth leading cause of death up to age 65. We would be happy to send, free of charge, information about liver diseases to anyone who provides us with a self-addressed, stamped envelope. The address: American Liver Foundation, 30 Sunrise Terrace, Cedar Grove, N.J. 07009. We all appreciate your continued concern for the health of our nation. — Thelma King Theil, Executive Director

Dear T.K.T.: On behalf of all my readers, thank you for letting us know about you.

OVER 36,000 REQUESTS FOR INFORMATION HAVE BEEN RECEIVED THUS FAR IN RESPONSE TO THESE TWO ARTICLES....AND MORE ARE BEING RECEIVED EACH DAY.

STATEMENT OF DR. HERBERT K. ABRAMS, DIRECTOR, ARIZONA CENTER FOR OCCUPATIONAL SAFETY AND HEALTH

The Occupational Safety and Health Act of 1970, PL-91-596, Section 21 (a), specifically charges NIOSH "to conduct directly or by grants or contracts educational programs to provide an adequate supply of qualified personnel to carry out the purposes of the Act ..."

Prior to the passage of the PL-91-596, the training of occupational safety and/or health specialists was performed in very few schools, most training being performed on the job. With the passage of the Act not only did the requirement for these specialists increase, but concomitantly, employers began looking for special skills and training which had previously been overlooked. These requirements were wisely foreseen by the Congress, and the direction cited above was incorporated into the wording of the Act.

To comply with the Act, and to provide a source of trained industrial hygienists, safety specialists, occupational physicians, and occupational nurses, NIOSH established a group of 12 regional Educational Resource Centers to provide training in the above-mentioned specialties.

In 1978 NIOSH published a report(1) of a survey of OSH personnel needs and availability. At that time it was predicted that existing educational institutional programs would increase their annual output as follows:

1977	1980	1985	1990
956	1438	1903	2158

Simultaneously, the survey showed there would be a need for between 3000 (status quo) and 4400 (expanding) new hires in all specialties annually, resulting at best in a severe shortfall.

Although the Educational Resource Centers cannot hope to overcome the shortfall by themselves, they can and do provide a cascading effect by (1) providing well-trained leaders for industrial teams, (2) training trainers, (3) providing continuing education for current field workers, (4) providing assistance to community and other schools training at the certificate level and (5) providing consultative services to industry, labor and the community. Thus the educational institution serves not only to train specialists, it is a true radiating center of educational and community services.

The U of A Center for Occupational Safety and Health cannot speak for the other centers; however, we feel that our experience is fairly typical of all. A summary of our training activities is shown in the enclosed table.

As you can see, after an initial organizational and development period, there has been dramatic growth in all areas; the growth being due to increased demand. As knowledge of the program availability and value has spread, so have the enrollment and requests for assistance grown. The increase is most dramatic in the area of Continuing Education. These short courses provide educational opportunities not only for the graduate specialist, but for the self-trained and community college trained individual. The enrollment speaks for the necessity to continue this program. We must remember that at least 95% of the attendees are industrially employed, indicating the recognition by industry that the occupational safety and health specialist is an important organizational component.

For as small a Center as ours, we feel that our output of professionals has been outstanding and that the distribution of these people through the industrial complex not only helps improve work conditions, but, as part of the management team helps reduce costs through reducing time off, workmen's compensation, and compliance problems.

In view of these considerations we strongly recommend that the FY 1981 NIOSH budget line item for training be retained at $13.1M, and further, in recognition of the importance of this particular facet of the NIOSH charter, the FY 1982 budget be increased to $15.06M.

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(1) A Nationwide Survey of the Occupational Safety and Health Work Force DHEW (NIOSH) Publication No. 78-164.

SUMMARY OF TRAINING ACTIVITIES
ARIZONA CENTER FOR OCCUPATIONAL SAFETY AND HEALTH
OCTOBER 1, 1977 to FEBRUARY 28, 1981

	YEAR				
Type of Training	77-78	76-79	79-80	80-81	Total
Professional Education Students					
Occupational Physicians, Nurses, Industrial Hygienists, Safety Specialists, and Toxicologists	37	56	69	98	260
Continuing Education Students Professional and Paraprofessional	37	772	413	1159	2381
Technical Assistance and Outreach Organizations Management, Labor, Academic and Government	104	171	226	372	873
			GRAND TOTAL		3514

STATEMENT OF NATIONAL HUNTINGTON'S DISEASE ASSOCIATION

The National Huntington's Disease Association is pleased to have this opportunity to provide for the record its comments on the National Institutes of Health Appropriations as they concern the funding for the National Institute for Neurological and Communicative Disorders and Stroke for Fiscal Year 1982. The Association has always appreciated the concern, understanding, and support it has received from this Subcommittee when it has previously submitted testimony.

Huntington's Disease is an inherited, neurological disorder. It is always fatal. Physical symptoms may include involuntary, jerking movements, loss of motor control, and changes in gait. Personality changes may appear, accompanied by loss of memory and decreased mental capacity. As Huntington's Disease progresses, mental deterioration causes changes in speech and memory.

Each child of a Huntington's Disease parent has a 50-50 chance of inheriting the disorder. There is no way of knowing who has inherited the gene for Huntington's Disease until the symptoms appear. The usual time of onset is between 35 and 45, but about 10 percent of cases occur in young people under 20. As there is no positive predictive test, people who are at risk—who have a parent with the disease—may have to wait a lifetime to know if they have been spared.

The etiology of the disease remains unknown; there is no effective treatment. Some medications used for schizophrenia provide some relief for the abnormal movements. Other drugs may relieve some of the symptoms of depression or other mood disturbances. No drug can treat the loss of mental faculties.

No reliable figures are available on the incidence or prevalence of Huntington's Disease. Patients are often misdiagnosed. Death certificates frequently do not record Huntington's Disease as a cause of death. Families hide the existence of the disorder. Current estimates put prevalence rates in the range of 4 to 7 per 100,000, although some recent studies suggest it may be as high as 10 in 10,000. Approximately twice the number are at risk for the illness.

Families affected by Huntington's Disease may pay for home care or institutional costs for upwards of 20 years. At the current price of $25,000 a year for nursing home care, costs can mount to $375,000 over 15 years. The costs of long-term care for Huntington's Disease patients are so high that health agency personnel sometimes advise the healthy spouse to get a divorce so that the patient can become a ward of the state and become eligible for medical benefits. Tragically, that may be the only way the well spouse can attempt to save to meet the future needs of children at risk.

Huntington's Disease is a family disease. Every member of the family is affected--emotionally, physically, socially--whether patient, at risk, or spouse. And the disease occurs not once, but over and over again in successive generations.

In 1977 the federal Commission for the Control of Huntington's Disease and Its Consequences report recommended that $15,775,000 be provided to implement the Commission's recommendations, which included additional funds for biomedical research and regional care centers. We are deeply appreciative of the fact that Congress recognized the urgency of this need in

August, 1978, when the Senate issued its Department of Labor/HEW Appropriation Bill Report for 1979, and stated: "The Committee expects that, with a significant portion of the additional funds provided for the Institute (National Institute of Neurological and Communicative Disorders and Stroke) it will implement as many as possible of those recommendations of the National Commission . . . on Huntington's Disease for which it has responsibility . . . The Committee's interest is very strong in Huntington's Disease and in genetic disorders. The Institute is, therefore, directed to closely coordinate its programs in this area with other Public Health Service programs and report back to the Committee on its progress and development of high-priority programs prior to next fiscal year's hearings."

The National Huntington's Disease Association is deeply concerned that the previous Administration's original budget figure for NINCDS is only $281 million--hardly a sufficient increase over last year's $253 million. We strongly urge that it be raised to $340 million. To maintain pace with a galloping inflation and ensure the stability of research projects already undertaken, an increased appropriation of at least $51 million is needed. Only with this additional $51 million will the Institute be able to fund approximately 50 percent of approved research grants. In addition, there exists a desperate need for increased training support, which was totally inadequate in FY 1980 and not increased in the FY 1981 budget. Postdoctoral fellowship positions dropped from 354 in the 1979 budget to 192 in 1980. Based on the amount of funds available for new starts in training in FY 1981 there will surely be a decrease in both individual and institutional awards. This deficit can only be met by transferring funds from the already strained research budget. An additional $5 million is necessary to prevent the erosion of medically trained personnel in this vital area of research.

Finally, if the Institute is to continue to implement the recommendations of the Commission for the Control of Huntington's Disease in accordance with the will of the Senate as expressed in previous Bill Report language, additional funds are needed. We are in agreement with and fully support the recommendation of the National Committee for Research in Neurological and Communicative Disorders, of which we are a member, that this Congressional Committee give careful consideration to approving an appropriation totalling $340 million for the Institute in Fiscal Year 1982.

Although the National Huntington's Disease Association is aware of the financial constraints that Congress must exercise, unless sufficient funds are appropriated, no new techniques or initiatives will be able to be effected by the Institute, and therefore many persons afflicted with neurological disorders, including those with Huntington's Disease, will suffer the consequences of inadequate funding.

We respectfully urge the members of this Subcommittee and the members of the Congress to give careful consideration to our request that the funding level for Fiscal Year 1982 for the National Institute for Neurological and Communicative Disorders and Stroke be approved at $340 million.

The National Huntington's Disease Association would be pleased to respond to any request for further information.

STATEMENT OF DR. JOHN WATKINS, CHILDREN'S HOSPITAL, PHILADELPHIA, PA.

The North American Society for Pediatric Gastroenterology has vigorously endorsed The National Commission on Digestive Diseases and its recommendations.

The Society further urges an increase of 10 million dollars over the current budget proposals for support of activities in Digestive Diseases. This would represent only 15 million dollars over last year's budget.

Digestive Diseases in children are common, often serious and frequently interfere with growth and development, yet expenditures for research into these disorders are woefully inadequate.

Of the priorities cited by The Commission report, we select the following as having greatest importance for children with Digestive Diseases:

1. Establish a National Digestive Disease Advisory Board. It is through this Board that pediatric Digestive Disease priorities for research and education will be established.

2. Support Training Programs in Pediatric Digestive Disease. Funds for training of medical and paramedical personnel in pediatric Digestive Disease are extremely limited. Progress here is mandatory.

3. Expand basic and applied clinical research. Knowledge of the causes, mechanisms, treatment and outcome of pediatric Digestive Diseases is lacking. A marked increase in funding in this area is likely to have important impact on preventing Digestive Diseases in adult life.

4. Identify influences of nutrition on Digestive Diseases, and of Digestive Diseases on nutrition. For Pediatric Gastroenterology this is a key area of emphasis. Dietary factors in causing pediatric Digestive Diseases have been largely ignored, as have the nutritional imbalances produced by pediatric Digestive Diseases. Research funds focussed here could have significance both for children and for adults whose diseases continue from a start in childhood.

The other priorities of The Commission have tremendous implications for pediatric Digestive Diseases and must be taken seriously:

Establish an information clearing house for the public, patients and medical personnel

Strengthen professional education in Digestive Diseases

Standardize terminology and diagnostic criteria for Digestive Diseases

Determine epidemiologic patterns of Digestive Diseases

Identify environmental and industrial pollutants as causes of Digestive Diseases

Funds directed toward pediatric research and prevention of Digestive Diseases have the greatest promise of influencing health status, changing patterns of disease and lowering health care costs.

STATEMENT OF FREDERIC M. RICHARDS, HENRY FORD II PROFESSOR OF MOLECULAR BIOPHYSICS, YALE UNIVERSITY

I appreciate the opportunity to submit a statement on behalf of the National Institute of General Medical Sciences. My present position is Professor of Molecular Biophysics at Yale University. I am a past president of the Biophysical Society and immediate past president of the American Society of Biological Chemists. A more complete biographical sketch is enclosed.

I wish to support strongly the statements of many of my colleagues on the importance of NIGMS as the principal source of funding for both the basic research and the research training which underlie the activities of all of the other categorical institutes. The Annual Reports of the Director provide an overview of these close and effective interactions. The voracious appetite of the American public for constantly improving medical care shows no sign of abating. The only source of quantum-jump improvements in the nature and cost of such care is the basic research enterprise. If it ever existed, any untapped store of fundamental knowledge in the biomedical area was used up years ago.

RESEARCH

My own field of research, the high resolution structure of proteins, appears to be about as remote from medical practice as any field supported by the Institute. We are interested in defining the three-dimensional structure of these biological macromolecules at, or close to, atomic resolution. The techniques of X-ray diffraction, magnetic resonance spectroscopy and neutron scattering, all borrowed from the physicists, play prominent roles. The latter technique can only be employed at the various National Laboratories such as Brookhaven or Oak Ridge where the necessary facilities exist. I mention this simply as an example of the strong interconnectedness of the entire scientific research enterprise.

A major focus in the area of protein structure work is enzyme catalysis. All biochemical reactions occurring in living organisms require catalysis to proceed at useful rates, and all biological catalysts are enzymes, i.e. proteins. There are two parts to the overall problem: specificity, that is, selection of the particular reaction that will be speeded up; and catalysis, the detailed chemistry in the active site where an interatomic bond is made or broken. While tremendous advances in our understanding of these processes have occurred during the past two decades we are still well short of the ability to 'design' a catalyst from first principles. However, the present intermediate state of our knowledge can still be very useful as I will try to indicate in the following example.

In 1967, Dr. William Lipscomb and his students at Harvard succeeded in working out the structure of the enzyme called carboxypeptidase or CPA. This enzyme is excreted by the pancreas into the intestine and is part of a group of enzymes responsible for digestion of food in the GI tract. CPA nibbles off amino acids one at a time from the end of the peptide chains of proteins taken in as food. One result of the structure work was a very detailed picture of a 'hole' in the enzyme into which the end of the chain to be cut actually fits. The action of this enzyme can be prevented by certain substances known as inhibitors. Soon after the structure report, Wolfenden and Byers at the University of North Carolina developed the compound benzylsuccinate as an inhibitor of CPA. The fit of the inhibitor in the hole was clear when molecular models were examined.

These two research programs turned out to have totally unexpected importance in the treatment of hypertension. Since hypertension is estimated to affect at least 5 to 10% of the population and to result frequently in serious cardiovascular difficulties, it can only be classified as a major medical problem.

Angiotensinogen is a peptide which normally circulates in the blood stream. Blood also contains an enzyme known as the Angiotensin Converting Enzyme or ACE. Very little is known in detail about ACE except that it cuts off two amino acids from the end of angiotensinogen converting it to angiotensin-II which is a potent vasoconstrictor causing an increase in blood pressure. It had been generally thought that inhibition of ACE would lead to lowered blood pressure, but the question was how to do it.

David Cushman and Miguel Ondetti at the Squibb Corporation reasoned that there might be similarities between CPA and ACE since they carry out similar functions on the same end of polypeptide chains. However the "hole" had to be different. They looked at the details of the CPA "hole" worked out by Lipscomb, and then designed one which might hold two amino acids rather than one at the end of a chain. They felt that if the hole in ACE really looked the way they predicted, then they should be able to design an inhibitor which would fit it. They did, it does, and the product of that work is the drug Captopril, an effective anti-hypertensive agent.

Neither Lipscomb nor Wolfenden were directing their work at a particular disease. In fact, they were not interested in diseases at all but rather in fundamental problems of enzyme catalysis. The CPA structure was announced in 1967. The Wolfenden and Byers report came out in 1973. Captopril was marketed in 1980. Considering the lead time required for drug certification by FDA, a more rapid transfer of basic science from the laboratory to the consumer cannot be expected.

The structure of the enzyme dihydrofolate reductase, of central importance in nucleic acid metabolism, has been worked out by Dr. Joseph Kraut at the University of California at San Diego. Merck is now heavily involved in designing efficient inhibitors of this enzyme, based on structural analogy, which are expected to provide markedly improved anticancer drugs. The work is successful and progressing rapidly with a marketable product expected.

In another area concerning the naturally occurring hormone somatostatin, Merck has developed long-lasting analogues which will be very important in the treatment of insulin-dependent diabetes. Again this work has been guided in an essential way by structural studies. The spectroscopic techniques employed in this work have been developed and validated by the studies over many years of a great many different individuals in universities with much of the research supported by NIGMS. The very recently developed field of computer assisted molecular graphics has been of enormous assistance in this particular study. This is another technique whose progress has been markedly assisted by NIGMS support.

These examples serve to emphasize that, in the biomedical area at least, technology transfer is not the bottleneck. The industrial sector will rapidly absorb any relevant basic research. The bottleneck is out lack of data and theoretical understanding at the basic research level. There is no backlog of scientific information on which the U.S. can coast while attempting to repair its economy. There will be a direct and instantaneously observable relationship between basic research output and industrial productivity. Budget adjustments should be made only with that fact clearly in mind. I would emphasize here that, in spite of its undirected nature, basic research is the cheapest and most financially effective of all the steps in the process of bringing products and improved techniques into the public domain.

RESEARCH TRAINING

The research enterprise requires facilities, equipment, and trained investigators. For the latter the required training period subsequent to the Bachelor's degree is usually about 7 to 8 years to produce truly independent research workers. This is divided into 4 to 5 years in a Ph.D. program and 3 years of postdoctoral research experience. The effectiveness of the entire research effort depends on a constant input of the best minds that we can find. It is in the national interest that this flow of trained investigators be maintained. Under any circumstances this is a highly self-selected group because, with very rare exceptions, the financial rewards are minimal.

In the biomedical area NIGMS has provided the major support for both pre- and postdoctoral training. This support has been in the form of institutional grants and of individual awards in national competition. Both forms play important roles. In the absence of this funding the supply of research personnel will shrink to a small trickle of those who can be self-supporting. No individual would be well advised to assume the massive debts which would be incurred during this long period of study when the prospects for paying them off by subsequent highly remunerative employment are simply not there. Even optimistically, scholarship funds at Universities could only pick up a tiny fraction of the current funding at the predoctoral level. University funds for postdoctoral fellowships are effectively non-existent. The difficulties are compounded by such facts as the existence of starting salaries on the order of $25,000 for individuals with a Bachelor's degree and with the modest level of computer expertise represented by a satisfactory grade in a few courses on the subject. Why should one bother with graduate school at all!

Note that training in research is essentially apprentice training; long, arduous, a one-on-one relation with the senior investigator, and intimate involvement in an on-going research program. The beginning of all current research programs occurred not with the award of a research grant but at the time the various investigators decided to enter a research career. A research program is a very delicate thing, it cannot be started and stopped the way one turns lights on and off in a house. For each individual there is a training period, followed usually by a dry period which appears unproductive, followed, with luck, by success. This process can be stopped essentially instantly at any time by the removal of funds, but it cannot be started again without a long incubation period and the assembly of a new research group. A significant decrease in funding for research training will be a strong signal to current undergraduate students that the national priorities have changed, that research is being downgraded, and their services in that area are not required. An attempt to correct such an impression a few years later by restoring the training funds would be treated with skepticism especially by the very brightest students which one would particularly hope to attract. You have these students today, but there is a serious risk of losing them.

The proposal to change the funding format by removal of the non-stipend portion of the training support is ridiculous. It has been reported in the public press that this action is intended to make the students so supported equivalent to their colleagues who do not pay such fees. There is no explanation as to who these other students are. In the biomedical area essentially all of the students are supported through government funding. The support pattern for different fields of scholarship vary enormously and cannot be usefully equated. In a general sense then, the reduction will simply cut either the research funds per laboratory member of the number of people engaged in research. The additional allowances heretofore available have defrayed the expenses to the research programs of the apprentice training component.

A portion of funds derived from tuition is used to provide teaching laboratories, but these are used for formal instruction and are not part of the research component of graduate or postgraduate instruction.

This nit-picking approach to budget reductions is much more counterproductive than the dollars involved might imply. If it is necessary for political reasons that each government program be perceived to suffer by having its budget cut, then these cuts should be made in the largest possible administrative units certainly not less than an entire Institute. The Institute staff are quite competent to distribute the cuts internally in a fashion which will be least damaging to the overall research and training programs. Neither OMB nor the Congress are in a position to do so nor should they attempt it.

The basic research enterprise in the U.S. has been an unqualified success to which the government, indeed all of us, can point with pride. The contribution of this research to the economy has been repeatedly documented. In its mandated area the National Institute of General Medical Sciences has run its programs supremely well. The Institute merits your strongest support.

CURRICULUM VITAE

FREDERIC M. RICHARDS

Personal Information:

Born: August 19, 1925
Married
Military Service: 1944-46

Education:

B.S., Masssachusetts Institute of Technology, 1948.
Ph.D., Harvard University, 1952.

Positions:

Research Fellow, Physical Chemistry, Harvard Medical School, 1952-53.
NRC Postdoctoral Fellow, Carlsberg Laboratory, Denmark, 1954.
NSF Fellow, Cambridge University, England, 1955.
Yale University, Assistant Professor of Biochemistry, 1955-59.
Yale University, Associate Professor, 1959-62.
Yale University, Professor, 1963-.
Yale University, Chairman, Department of Molecular Biology and Biophysics, 1963-67.
Yale University, Chairman, Department of Molecular Biophysics and Biochemistry, 1969-73.
Jane Coffin Childs Memorial Fund for Medical Research, Director, 1976-.

Awards and Membership in Professional Organizations:

Recipient of Pfizer-Paul Lewis Award in enzyme chemistry, 1965.
Guggenheim Fellow, 1967-68.
Kai Linderstrøm-Lang Prize in Protein Chemistry, 1978.
American Chemical Society.
American Society of Biological Chemists, 1957- ; President, 1979-80.
Biophysical Society; President, 1972-73.
American Crystallographic Association.
Editorial Board of Journal of Biological Chemistry, 1963-69.
Editorial Board of Journal of Molecular Biology, 1973-75.
Editorial Board of Advances in Protein Chemistry, 1963-.
Member of the National Academy of Sciences, 1971-.
Fellow of the American Academy of Arts and Sciences, 1970-.
International Union of Pure and Applied Biophysics; Council, 1975-(1981).

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Professional Field:

Biochemistry/Biophysics - Protein Structure, X-ray Crystallography, Mechanism of Enzyme Action, Chemical Modification of Proteins, Structure of Membrane Proteins and Membrane Topology, Theoretical Studies in Protein Structure and Dynamics.

Research Support:

National Institute of General Medical Sciences
National Science Foundation

Publications:

Approximately 80 original research articles and 8 scientific reviews.

STATEMENT OF DR. DAN MCNAMARA, PRESIDENT, AMERICAN COLLEGE OF CARDIOLOGY

I am Dr. Dan G. McNamara, Professor of Pediatrics and Chief of the Cardiology Section, Baylor College of Medicine and Texas Childrens Hospital, Houston. I am also President of the American College of Cardiology; it is in this latter capacity that I submit this testimony for the record.

The American College of Cardiology is a professional medical specialty society representing more than 11,000 specialists in heart disease, circulatory disorders, and related disease. The College appreciates the opportunity to present before this important Committee our views regarding the FY 1981 appropriations for the National Heart, Lung and Blood Institute and the National Library of Medicine.

National Heart, Lung, and Blood Institute

In the February 26, 1981 NEW ENGLAND JOURNAL OF MEDICINE* (Vol. 304, No. 9, pages 509-17), NIH Director Dr. Donald Fredrickson expressed the following concern:

> "The new Administration could be the most fiscally constrained in half a century, and

> yet it must endeavor to provide full support to a revolution. This is the best word to describe the present state of biological sciences. The economic foundation, however, has rarely been more precarious".

This brief statement articulates the dilemma which we know you are facing as guardians of the public coffers. Our society is faced with difficult choices involving the allocation of very limited fiscal resources. We offer our comments and recommendations as advice from individuals who conduct biomedical research, teach the researchers of the coming decades, and apply the advances of biomedical research to the day-to-day treatment of our patients. In this context, we wish to discuss those areas of the NIH budget in general, and the budget of the NHLBI in particular, which are worthy of these scarce Federal dollars.

It is difficult to examine the progress that has been made in combating cardiovascular disease during the past decade without concluding: (1) that NHLBI has been in the forefront of these strides; (2) that cardiovascular research has been a cost-effective Federal investment which has yielded substantial dividends in terms of reduced morbidity and mortality and correspondingly, reduced health care expenditures; and (3) that support for basic research, as you indicated in a recent WASHINGTON STAR editorial by Senator Schmitt, is the true prerequisite for prevention.

The knowledge attained through basic and applied research during the past thirty years has led to tremendous advances in combating and preventing cardiovascular diseases. Recent studies supported by the NHLBI have shown an important relation between the level of high-density lipoprotein (HDL) in the blood to the risk of coronary heart disease. Other NHLBI studies have resulted in: the design of new support devices to help the heart maintain its pumping function during the acute period just after a heart attack; the further developments of coronary bypass surgery; and the use of radioactive isotopes in evaluation of the state of the heart muscles and in assessment of the heart's effectiveness in pumping blood. These are just a few of the developments that have resulted from NHLBI-supported research.

In the area of new technology, cardiac pacemakers can be singled out as devices that have increase,life span, and improved lifestyles in many thousands of patients. Moreover, the development of non-invasive diagnostic techniques, e.g., cardiography, computerized technology, and radionuclide procedures have resulted in safer, more accurate, and more economical methods of diagnosis of cardiovascular disease.

We need not reiterate the exciting results that Dr. Robert Levy discussed in his recent testimony before this Subcommittee regarding the Institute's clinical trials and prevention education,and control programs.

The success of the NHLBI in meeting your mandate can be documented in numbers as well. Largely due to the Institute's comprehensive program, the national cardiovascular mortality rate has decreased over 30% in the last 25 years. Cardiovascular mortality has fallen by over 10% in every adult age grouping, in both sexes, and in both majority and minority populations. The impact is made even more dramatic when one considers the statistic that, had not this trend developed, there would be 300,000 more cardiovascular deaths each year than the number that actually occur. Life expectancy in the United States has increased during the past three decades by nearly 15 years; a significant portion of this increase in life expectancy can be attributed to the decline in cardiovascular death rates.

However, the acknowledgement of the above achievements and documented successes should not let us forget the grim fact that cardiovascular disease still accounts for more than 50% of all deaths in this Nation, and that, each day, heart attacks strike 3,400, and strokes another 1,600 Americans. An estimated 60 million Americans have hypertension, a major risk factor of both heart attacks and stroke. Accordingly, these problems must be vigorously pursued by the Institute, and we offer the following recommentations as a means of assuring that the NHLBI will have the ability to meet its mandate to the maximum possible extent.

The American College of Cardiology believes that the aforementioned demonstrates that NHLBI programs have been effective and have saved, and will continue to save, billions of Federal and private health treatment dollars. As such, reductions in the NIH budget must be carefully scrutinized. Total private sector biomedical research support is but a small fraction of the Federal contribution.

The Administration's proposed budget for FY 1981 and FY 1982 could have a long-term deleterious impact on NIH research programs. If Congress were to approve the $21 million rescission in the NHLBI's FY 1981 appropriation, the Institute would be able to support only 29.4% of its approved research grant applications, and under the Administration's FY 1982 budget, only 31.1% of approved research grants. The NHLBI would be able to fund only 644 research grants in FY 1981 and 739 research grants in 1982. This situation is particularly distressing when one considers that in 1979, the Institute supported 942 research grants, and throughout the mid-1970's, the Institute was able to fund 40% to 50% of its approved grants. These disturbing trends would be exacerbated under the Administration's FY 1982 NHLBI budget request of $579.8 million (an increase of only 3% over the current FY 1981 continuing resolution level).

The College believes that ample funds should be allocated to NHLBI to enable it to fund at least 35% of its approved research grants, and our proposed funding level so reflects.

The American College of Cardiology is particularly concerned with the precarious state of manpower training in the Federal biomedical research community. Within the constraints of available resources, the NHLBI has been dedicated to training more investigators in research areas related to cardiovascular, pulmonary, and blood diseases. Despite this commitment, the number of trainees in the heart and vascular areas has decreased by almost 40% during the past decade. Even more disturbing, the number of trainees who are clinical investigators (i.e., trainees with an M.D. degree) has declined by two-thirds.

Most of the Administration's proposed FY 1981 rescission would be excised from the National Research Service Awards allocation. The total number of NIH-supported trainees would be reduced from about 10,600 to about 10,000. The number of trainees supported by the NHLBI would be cut from 1,647 to 1,516.

The need for trained scientists has grown well beyond that required for replacing senior colleagues who retire or move on to other endeavors. The proposed policy is transmitting a resounding message to young physicians and Ph.D.s that the sacrifices necessary to pursue a research career are not justified, or for that matter, appreciated. It is certain that a fiscal neglect of training today will spell disaster to our country's biomedical research efforts of tomorrow. Providing training that will enable the next generation of biomedical scientists to build upon knowledge acquired in this decade is the best available investment for the maintenance and protection of future medical science. Accordingly, our recommendation for the NHLBI would provide for a modest 10% increase in the number of full-time equivalent trainees.

The American College of Cardiology also supports the NHLBI's National Research and Demonstration Centers, Specialized Centers of Research, clinical trials, intramural research, and prevention, education, and control activities. Our recommendations have been developed with fiscal restraint in mind and are geared toward maintaining these activities at current programmatic levels.

National Library of Medicine

The mission of the National Library of Medicine is to assist the advancement of medical and related sciences for the collection, dissemination, and exchange of information important to the progress of medicine and health. As medical science has yielded research knowledge, medical and scientific literature have proliferated. The NLM has been faced with a vast growth in the volume of literature (110% over a ten-year period) and a significant increase in the demand for basic library services. On-line searches of NLM's data base, a service vital to the advancement of medical research, has risen to more than 1 million per year.

This Committee has always indicated its desire to assure the expeditious transfer of research results "from bench to bedside." The NLM is in a unique position to facilitate this objective. The College recommends that $49.0 million be appropriated to the NLM to enable it to: complete its MEDLARS III information service; continue to acquire the world's medical literature despite increased annual medical journal costs of 15-20%; and expand its regional medical library program to assure that medical information is available to practitioners in areas where medical library services are scarce.

Thank you for providing the American College of Cardiology with an opportunity to present our views regarding FY 1982 NIH appropriations.

RECOMMENDATIONS OF
THE AMERICAN COLLEGE OF CARDIOLOGY
FOR THE
NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

(in millions of dollars)

	Administration Budget Request FY 1982	ACC Recommendation FY 1982	
Research	414.0*	426.4 --	would enable NHLBI to support 35% of its approv research grant application
Research Training	24.7	38.4**--	would enable NHLBI to support a 10% increase in the number of FTE trainees.
Research and Demonstration Contracts	61.0	61.0	
Intramural Research	49.5	49.5	
Direct Operations and Program Management	33.7	33.7	
	582.9	609.0	

*Assumes that no FY 1981 funds are rescinded from NHLBI budget.

**Assumes continuation of institutional support at current levels.

STATEMENT OF AMERICAN SOCIETY OF INTERNAL MEDICINE

The following are the official comments of the American Society of Internal Medicine (ASIM) on federal appropriations for the health planning program created by the National Health Planning and Resource Development Act of 1974 (PL 93-641) and its subsequent amendments. We respectfully request that this statement be included in the official records of the hearings on this subject.

ASIM is a federation of 51 state component societies (including Puerto Rico) with a membership of more than 17,000 physicians who specialize in internal medicine. Unlike many other medical organizations, ASIM has never before called for repeal or cessation of funding for the health planning program. Despite our concerns about the program, we have expended considerable time and resources since January 1975 in support of local implementation of Public Law 93-641. We have repeatedly urged internists to become involved in their HSAs by offering to serve on the governing boards or their advisory groups. We have also commented on several sets of proposed rules and have arranged for practicing internists to meet with Bureau of Health Planning officials to discuss implementation of the program. In addition, two issues of our national publication, The Internist, have been devoted to educating our members about health planning.

Our objective in pursuing all of these activities has been to further the effectiveness of local, community based health planning.

In recent months, however, we have reassessed our position on the federally mandated health planning program. Our reassessment involved evaluation of the experiences of those of our grass roots members who have attempted to participate in local health planning, as well as careful analysis of the research literature that has been conducted on health planning. The comments of our members and the reports from the research literature have led us to conclude that federally funded and mandated health planning has not worked.

For this reason, ASIM now favors repeal of PL 93-641 and, as an interim measure, a phase out of funding for the program as has been proposed by the Administration.

Six years after the program was created by Congress, it has become apparent that federally mandated health planning is fundamentally flawed and ultimately unworkable. The federal government--by continuously issuing regulations and "guidelines" that restrict the flexibility of local health systems agencies--has demonstrated an unwillingness to allow local communities to determine their own needs and to develop their own solutions. Practicing physicians who have attempted to participate in local planning decisions have been frustrated by federal regulations and statutory requirements designed to restrict physician participation in the system.

ASIM believes that the input of practicing physicians is crucial to effective health planning. Because of their medical expertise and their position as the focal point of medical care delivery, physicians possess an important perspective no one else can provide. It has been suggested that physicians make the decision on 85 percent of all medical care expenditures. Yet, under current law, practicing physicians are not even guaranteed a position on HSA governing bodies.

Consequently, it is not surprising that most objective analyses have found that the current program has failed to meet its own goals--specifically, it has not saved money, or improved the quality of, or access to, health services. Indeed, it often seems to have had the opposite effects. A 1978 DHHS-funded study entitled Certificate of Need Programs: A Review, Analysis, and Annotated Bibliography of the Research Literature surveyed all of the independent research that had been conducted on the Certificate of Need laws required by PL 93-641 and concluded that :

> "There are apparently no studies offering direct evidence that CON controls have curbed overall health care cost increases... The

evidence that does exist does not encourage much optimism about CON's ability to curb health care inflation."

"More research clearly needs to be done on the administrative and compliance costs imposed by CON laws. Direct costs may not be unduly high, but none of the literature surveyed looked in any detail at the indirect costs. Examples of indirect costs include extra hospital time devoted to planning, and the higher construction costs, which hospitals claim were caused by construction delays arising out of CON processes."

Similiarly, a December, 1980 study published in the New England Journal of Medicine (303:25) entitled "Duplicated Hospital Facilities: How Much Can We Save by Consolidating Them" concluded that federal efforts to eliminate duplication--one of the primary objectives of the health planning program--will not result in significant cost savings due to increased indirect costs resulting from consolidation, such as those incurred by moving patients from one facility to another.

ASIM recognizes the need to minimize unnecessary institutional expansion and to allocate health care resources in a more rational manner. For this reason, we continue to support local, community based health planning, provided that it is not mandated, funded or regulated by the federal government. We also support comprehensive reforms in the reimbursement system to reduce the current incentives for hospital expansion and inefficient administration. Introducing greater competition in the health care system also holds some promise for reducing costs and unnecessary institutional expansion.

However, we believe that taxpayers should not be asked to support a federally controlled health planning program that is ineffective, costly, and burdensome. We strongly urge the committee to support President Reagan's proposal for a phase out of federal funding for the program.

STATEMENT OF DANIEL R. HAWKINS, JR., NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

MY NAME IS DANIEL R. HAWKINS, REPRESENTING THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS. OUR ORGANIZATION REPRESENTS OVER 1,200 COMMUNITY-BASED, PRIVATE NON-PROFIT HEALTH CENTERS AND PROJECTS PROVIDING PRIMARY CARE SERVICES TO MEDICALLY-UNDERSERVED, DISADVANTAGED POPULATIONS IN ALL 50 STATES, PUERTO AND THE DISTRICT OF COLUMBIA. THESE PROGRAMS PROVIDE HEALTH SERVICES TO OVER SIX MILLION AMERICANS.

I AM DEEPLY CONCERNED ABOUT THE PRESIDENT'S BUDGET AND LEGISLATIVE RECOMMENDATIONS FOR A SO-CALLED ECONOMIC RECOVERY. WHILE I AS A TAXPAYER UNDERSTAND CLEARLY THE DESIRE FOR RESTRAINT IN PUBLIC SPENDING AND ABOVE ALL THE NEED TO CONTROL INFLATION, THE PRESIDENT'S "MEAT AX" APPROACH IN THE AREA OF HEALTH IS NOT ONLY IRRESPONSIBLE, BUT IS A SHAM.

- WHILE HIS PROPOSAL IS BEING SOLD AS A MEANS TO REDUCE SPENDING, IT WILL IN FACT MERELY SHIFT THE BURDEN AND ADD COSTS AT THE STATE AND LOCAL LEVELS.

- WHILE THE PROPOSAL IS SOLD AS A MEANS OF REDUCING OVERHEAD AND REGULATION, IT WILL IN FACT INCREASE BOTH OF THOSE AREAS BY SHIFTING PROGRAM MANAGEMENT TO 50 STATES, PLUS TERRITORITIES AND LOCALITIES.

- ABOVE ALL, THE PRESIDENT CLAIMS HIS CUTS WILL NOT HURT THE TRULY NEEDY BUT ARE MERELY A BELT TIGHTENING EXERCISE. I CAN ASSURE YOU THE COMPOUND EFFECT OF THE PROPOSED CUTS WILL IN FACT HAVE A DEVASTATING IMPACT ON LOWER INCOME FAMILIES, THE VAST MAJORITY OF WHICH ARE WORKERS AND TAX-PAYING CITIZENS.

I SINCERELY HOPE WE CAN EXPECT A MUCH MORE RESPONSIBLE APPROACH BY THE CONGRESS. IT IS UNFORTUNATE THAT CITIZENS WHO STRUGGLE

DAILY WITH INFLATION HAVE THE GOVERNMENT AS THEIR ONLY RELEASE VALVE. IT IS INDEED A SHAME WE CANNOT AS EFFECTIVELY COMMUNICATE OUR CONCERNS TO OIL COMPANIES, UTILITIES, HOSPITALS, AND GROCERS, ALL OF WHICH SHARE AS CULPRITS IN THE INFLATIONARY SPIRAL.

BUDGET IMPACT

CONCERNING THE PROPOSED BUDGET CUTS AND BLOCK GRANTS, I WANT TO ADDRESS TWO AREAS:

- THE MEDICAID CAP
- PRIMARY HEALTH CARE - COMMUNITY AND MIGRANT HEALTH CENTERS

BOTH PROGRAMS SERVE POOR AND LOW-INCOME FAMILIES, WHICH I ASSURE YOU ARE TRULY NEEDY, AND MEET NOT A LUXURY BUT A BASIC HUMAN NEED - HEALTH CARE.

I. MEDICAID CAP

I HAVE DISCUSSED THIS ISSUE AT LENGTH WITH MEMBERS OF MY ASSOCIATION'S HEALTH POLICY COMMITTEE COMPOSED OF REPRESENTATIVES FROM THE 50 STATES. OUR MEMBERS ARE HEALTH CARE PROVIDERS INCLUDING REPRESENTATIVES OF HOSPITALS AND PUBLIC FACILITIES, WHO, IN TURN, HAVE DISCUSSED THE PROPOSAL WITH STATE AND LOCAL PUBLIC OFFICIALS.

AS YOU ARE AWARE, THE PROPOSAL WOULD:

A. REDUCE FEDERAL FUNDING FOR MEDICAID BY $100 MILLION IN FY 81, $1 BILLION IN 82, AND GREATER AMOUNTS THEREAFTER, AND

B. ELIMINATE MANDATORY ELIGIBILITY AND SERVICE REQUIREMENTS.

IN DISCUSSING THE ADMINISTRATION'S PLAN, THE CLEAR CONSENSUS ABOUT THE IMPACT OF THIS PLAN IS THAT:

1. STATES WILL REDUCE ELIGIBILITY, THEREBY ELIMINATING SERVICES TO AS MANY AS 1.4 MILLION PEOPLE - ALL OF WHOM HAVE INCOMES BELOW THE POVERTY LEVEL.

2. STATES WILL ELIMINATE PAYMENT FOR CERTAIN SERVICES STARTING WITH PREVENTION, EPSDT, PRIMARY CARE OR "OUTPATIENT" SERVICES, AND CLINIC SERVICES IN ORDER TO MEET THE MUCH MORE EXPENSIVE AND INCREASING COST OF INPATIENT CARE.

3. SOME STATES AND LOCALITIES WILL ATTEMPT TO RAISE LOCAL TAXES OR INSTITUTIONS WILL ATTEMPT TO INCREASE COSTS TO INSURED PATIENTS WHICH WILL BE RESISTED BY CITIZENS AND INSURERS.

4. LESS THAN HALF THE PHYSICIANS IN THIS COUNTRY TREAT MEDICAID PATIENTS - AND THE NUMBER IS DWINDLING. THIS PROPOSAL WOULD REDUCE THE NUMBER SUBSTANTIALLY GIVEN THE EXPECTED REDUCTION IN PHYSICIAN FEES.

II. PRIMARY HEALTH CARE PROGRAMS

THE PRESIDENT HAS PROPOSED TO CONSOLIDATE SEVERAL HEALTH SERVICE PROGRAMS INTO A STATE BLOCK GRANT, AND TO REDUCE FUNDING BY 25%. INCLUDED AMONG THESE ARE COMMUNITY AND MIGRANT HEALTH CENTERS. THESE CENTERS, OF WHICH THERE ARE 1,072 THAT ARE FEDERALLY ASSISTED, PROVIDE BASIC HEALTH SERVICES TO 5.5 MILLION PEOPLE IN MEDICALLY UNDERSERVED AREAS. THE VAST MAJORITY OF INDIVIDUALS SERVED ARE LOW INCOME AND HAVE NO OTHER SOURCE OF HEALTH CARE. THEY ARE EITHER GROSSLY UNDERINSURED OR HAVE NO HEALTH INSURANCE. THESE PROGRAMS WERE CREATED BY THE FEDERAL GOVERNMENT TO PROVIDE HEALTH CARE TO POPULATIONS OR AREAS WHICH FOR YEARS HAVE BEEN NEGLECTED BY THE PRIVATE AND PUBLIC SECTORS FOR NUMEROUS REASONS BUT MAINLY BECAUSE OF INADEQUATE INCOMES.

THE BUDGET CUTS PROPOSED BY THE PRESIDENT WOULD RESULT IN THE TERMINATION OF SERVICES TO SOME 2,180,000 PEOPLE AND THE CLOSING OF 445 CENTERS. AS A CONSEQUENCE, 4,500 LOCAL

JOBS IN THE HEALTH PROFESSIONS WOULD BE ELIMINATED AND WE WOULD SEE THE TERMINATION OF SOME 5,400 CONTRACTS WITH LOCAL HOSPITALS, PHARMACEUTICAL SUPPLIERS, EMPLOYMENT AGENCIES, BANKS, PRIVATE PHYSICIANS, LABS, ETC. AMOUNTING TO APPROXIMATELY $200,000,000.

SHOULD THE "BLOCK GRANT" BE ADOPTED IN ADDITION TO THE OTHER SPENDING CUTS, IN SUCH HEALTH RELATED PROGRAMS AS THE NATIONAL HEALTH SERVICE CORPS, MEDICAID, FAMILY PLANNING, MATERNAL AND CHILD HEALTH, AND WIC, THE LOSS WOULD BE MUCH GREATER. I SAY THIS BECAUSE MOST OF THE CENTERS ARE FUNDED AT "BARE-BONES" LEVELS NOW. FOR THE PAST FIVE YEARS WE HAVE WORKED HARD AT EFFICIENCY. NO FACT SPEAKS MORE CLEARLY THAN THE REDUCTION IN OUR COST PER COMPREHENSIVE HEALTH ENCOUNTER FROM $44 IN 1974 TO $32 IN 1979 -- A DECREASE OF 27% -- WHILE HEALTH COSTS IN OTHER SECTORS ROSE 55% DURING THE SAME PERIOD.

MOREOVER, MOST CENTERS OPERATE SEVERAL PROGRAMS, IN AN INTEGRATED FASHION, AND DEPEND UPON THE NATIONAL HEALTH SERVICE CORPS TO ASSIST IN PROVIDING HEALTH MANPOWER. A 25% CUT IN ALL THE PROGRAMS, OR EVEN SEVERAL, WOULD PUT A NUMBER OF CENTERS OUT OF BUSINESS.

SHOULD THE PRESIDENT'S HEALTH PROPOSAL FOR THESE PROGRAMS BE ADOPTED, COUPLED WITH MEDICAID REDUCTIONS, THE FOLLOWING ARE SURE TO HAPPEN:

1. MILLIONS OF INDIVIDUALS WILL BE DENIED A BASIC HUMAN NECESSITY - HEALTH CARE, RESULTING IN SUFFERING, DISEASE, LACK OF PRODUCTIVITY AND PREMATURE DEATH. THE PROPOSED CUTS WOULD AFFECT OVER 3 MILLION PEOPLE.

2. THOSE PHYSICIANS AND HOSPITALS WHICH MAY ATTEMPT TO SHARE SOME OF THE LOAD OF CARING FOR THE UNDERINSURED, WILL BE FORCED TO PASS

THE COST ON TO INSURED PATIENTS -- FURTHER ESCALATING HEALTH COSTS; AND SOMEONE WILL HAVE TO PAY - WHETHER THROUGH TAXES, INSURANCE OR OUT-OF-POCKET.

3. FEDERAL BUREAUCRACY WILL BE REPLACED BY STATE BUREAUCRACIES AND REGULATIONS-AT MUCH ADDITIONAL COST. FOR EXAMPLE, THE CURRENT COST, AS A PERCENT OF TOTAL PROGRAM COSTS, FOR ADMINISTERING THE HEALTH CENTER PROGRAM IS 3% COMPARED TO THE STATE ADMINISTERED MCH PROGRAMS IN EXCESS OF 10%. WHEN YOU EXAMINE COMPARABLE ADMINISTRATIVE COSTS, STATES EMPLOY ONE PERSON TO ADMINISTER EACH $26,000 OF EXPENDITURES WHILE THE FEDERAL GOVERNMENT EMPLOYS ONE PERSON TO ADMINISTER EACH $207,000 OF EXPENDITURES. BASED ON THESE PATTERNS, IT WOULD TAKE 8 TIMES AS MANY PEOPLE TO ADMINISTER THESE PROGRAMS AT THE STATE LEVEL AS IT WOULD AT THE FEDERAL LEVEL. ALSO, IT IS INTERESTING TO NOTE THE ADMINISTRATION'S JUSTIFICATION FOR THE MEDICAID CAP IS "... THE UNWILLINGNESS OR INABILITY OF MANY STATES TO MANAGE THE PROGRAM IN A COST EFFECTIVE WAY." IT WOULD APPEAR THAT IN PROPOSING BLOCK GRANTS AS AN ALTERNATIVE THE ADMINISTRATION IS SPEAKING OUT OF BOTH SIDES OF ITS MOUTH.

4. MOST STATES AND LOCALITIES WILL BE FORCED TO INCREASE LOCAL TAXES TO MEET THE TREMENDOUS NEED OF THE DISENFRANCHISED, ABOVE AND BEYOND THE 21 MILLION PEOPLE WHO HAVE NO HEALTH INSURANCE AT ALL.

5. CIVIL UNREST - A SEVERE REACTION BY THOSE WHOSE LIVES ARE MADE MISERABLE. AND MR. CHAIRMAN, HOW WOULD YOU OR I, OR ANY MEMBER OF CONGRESS REACT IF IT WAS OUR MOTHER, FATHER, SON OR DAUGHTER WHO WAS SERIOUSLY

ILL OR DYING AND WE COULD NOT EVEN SEE A DOCTOR, A NURSE, OR GET CARE.

MR. CHAIRMAN, I HAVE CALLED THE ADMINISTRATION'S HEALTH PROPOSALS A SHAM BECAUSE THEY ARE BEING SOLD UNDER FALSE PRETENSES. THEY WILL SERIOUSLY AFFECT THE "TRULY NEEDY," WILL ADD TO INFLATION, AND WILL RESULT IN MORE ADMINISTRATIVE COSTS AND REGULATION - ALBEIT AT THE STATE LEVEL. I UNDERSTAND THE ADMINISTRATION'S DESIRE TO PRODUCE QUICKLY FOR THE PUBLIC - BUT THIS APPROACH WILL BACKFIRE ONCE IT HITS PEOPLE.

I DO WHOLEHEARTEDLY AGREE WE NEED TO TIGHTEN OUR BELTS; BUT I ALSO BELIEVE WE SHOULD PROVIDE INCENTIVE FOR PROGRAMS WHICH DO REDUCE COSTS AND PENALIZE THOSE THAT DON'T -- IN BOTH THE PUBLIC AND PRIVATE SECTORS. DO YOU REALIZE THAT THE BUDGET INCREASE FOR 1982 IN MEDICARE ALONE IS MORE THAN TRIPLE THE AMOUNT OF PROPOSED CUTS IN HEALTH? CAN WE CONTINUE ON THIS PATH? I SAY NO.

LET ME BRIEFLY EXPLAIN WHAT PRIMARY CARE CENTERS HAVE DONE TO CONTAIN COSTS. BETWEEN 1974-1979, THEY HAVE:

- INCREASED THEIR PATIENT LOAD BY 250%, WHILE APPROPRIATIONS INCREASED ONLY 47% AND INFLATION IN HEALTH CARE EXCEEDED 55%.

- INCREASED PATIENT PAYMENTS (FROM LOW-INCOME PEOPLE)AND THIRD-PARTY RECEIPTS BY 123%

- INCREASED PHYSICIAN PRODUCTIVITY BY 31%

- REDUCED ADMINISTRATIVE COSTS BY 16%

- REDUCED THE COST PER ENCOUNTER 27% DESPITE AN INFLATION RATE OF 55%.

WHAT OTHER HEALTH PROVIDER CAN CLAIM THIS RECORD?

NUMEROUS STUDIES SHOW THAT:

- HEALTH CENTERS REDUCE HOSPITALIZATION BETWEEN 25%-66%

- HEALTH CENTER COSTS ARE 33%-60% LESS THAN ALTERNATIVE MODELS (HOSPITAL OUTPATIENT DEPARTMENTS AND EMERGENCY ROOMS)

- THE MEDICAID COST FOR A PATIENT TREATED BY A HEALTH CENTER IS 40% LESS THAN A MEDICAID PATIENT SEEN BY OTHER PROVIDERS.

MY REAL QUESTION, THEN, IS WHY IS THIS PROGRAM BEING PROPOSED FOR CUTS? HEALTH CENTERS HAVE EFFECTIVELY CONTAINED AND REDUCED COSTS WHILE HOSPITAL COSTS ROSE 16% AND PHYSICIAN COSTS ROSE 14% LAST YEAR ALONE. OVER A FIVE OR TEN YEAR PERIOD, THE DIFFERENCES ARE EVEN MORE STRIKING.

AND WHAT ABOUT MEDICAID? LESS THAN 1/3 OF THE POOR NOW QUALIFY FOR COVERAGE. AND WHAT ABOUT THE 21 MILLION PEOPLE WITH NO INSURANCE AT ALL? WILL MEDICARE FALL PREY TO THE ADMINISTRATION'S HASTY BUDGET-CUTTING ZEALOTS AFTER 1982?

MR. CHAIRMAN, I DON'T THINK IT IS A MATTER OF MORE AND MORE MONEY - WE NEED TO MANAGE OUR MONEY MORE EFFECTIVELY. I THINK POSITIONS SHOULD BE JUSTIFIED REWARDING THOSE WHO HOLD DOWN COSTS. YOU AND THIS COMMITTEE, I REALIZE, HAVE SOME SHORT DEADLINES AND COULD POSSIBLY TAKE THE EASY WAY OUT. I TRUST INSTEAD THAT YOU WILL GIVE DIRECTION AND TAKE RESPONSIBLE ACTION.

I WOULD BE HAPPY TO ANSWER ANY QUESTIONS.

FY 82
NACHC RECOMMENDATIONS
AND
BUDGET JUSTIFICATION

	$ (in millions)
COMMUNITY HEALTH CENTERS (PHS Act Secs.330,328,340 - includes Black Lung and Hospital-Affiliated Primary Care Centers)	$397
Primary Care Research & Demonstration (Sec. 340)	$ 8
Migrant Health Centers	$ 56

I. Community Health Centers

The above figures would:

A. Allow for the maintenance of services at 984 existing centers

B. Make operational ten (10) hospital-affiliated primary care centers

C. Allow for continuation of 56 existing Black Lung Clinics

D. Allow for the expansion of 91 existing centers

E. Allow for an additional 265,000 new users at $68.00 per person.

Independent studies show that Community Health Centers provide quality care in an efficient manner. Health centers costs are 33 to 50 percent lower than hospital outpatient departments or emergency room costs and 41 percent lower than average Medicaid ambulatory care costs.

II. Migrant Health Centers

The appropriation of $56 million for FY 82 would:

A. Allow for maintenance of current services at 122 existing sites

B. Allow for expansion of the hospitalization program

C. Provide services for 50,000 new users

D. Allow for service of 4,000 women in 10 birthing centers.

Currently, this program serves only 21 percent of the migrant and seasonal farmworker population. Needs assessments show that migrants have higher rates of communicable disease and parasitic infections than the general population. In addition, the proportion of migrant births outside of the hospital is nine times the national average.

STATEMENT OF HEALTH POLICY COUNCIL

The enabling legislation for the Health Systems Agency charges them with a commitment to health promotion and disease prevention. So far, the Health Systems Agencies have, in general, not kept this commitment. The rhetoric of health promotion has been included in plans and decisions, but there has been too little substantive accomplishment. The Agencies have become mired in a regulatory function at the expense of addressing and directing the lifestyle changes and societal changes now taking place in the nation toward health.

Despite this relative failure, the Health Systems Agencies do represent an attempt at participatory policy-making in the area of health. Arguments over the definition of "consumer" and "provider" abound, but the basic principle is one which deserves support: Health is too important to leave to physicians and hospital administrators. For this reason, the Health Policy Council urges the Committee to keep the HSA structure in tact. The Agencies allow valuable public input into the health planning process. Funding should be maintained if possible, and if not, cuts should be made that are equitable with those affecting other programs.

Moreover, the Health Systems Agencies provide a watchdog function over costs, duplication of health care services. It makes little sense to gut a program as a cost-cutting measure that, if improved, could play a vital cost-reducing role.

The position of the Health Policy Council is that the HSA's should be required to include health promotion as an essential part of its planning function.

Second, budget cuts, if necessary, should be no more than those affecting other programs.

Health Systems Agencies can play an important role in democratizing the health planning process. Where weaknesses exist, the solution is not to scrap the program but to solve the problems.

OTHER CONCERNS

An important purpose of the Health Policy Council is to encourage policies that promote health and prevent disease on the governmental, corporate, and personal level. Another major purpose is to encourage health education so that all citizens can participate in health policymaking. Any individual can become a member of the Council with interest in helping to develop positive health programs. An advisory board of distinguished health promotion experts functions as the communication body of the Council.

In regard to health policy, the Council believes that each level has its own responsibility: the individual (consumer, providers), the community (organizations, interest groups, hospitals, private industry,, and government (local, state, and federal). In order for the total system to be successful, each level must be supportive of one another.

In keeping with our goals, we recognize that this is an opportune time to influence the development of health policy toward health promotion. Health promotion is defined by the World Health Organization as: "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

The Council is aware that the federal government has accomplished a great deal in the area of public health in its successful efforts to combat communicable diseases. Also, there has been conserted efforts toward health prevention in recent years. We applaud the government in these areas. Extensive studies has been produced regarding the effectiveness of health promotion. In 1979, the Surgeon General's Report on Health Promotion and Lisease Prevention: Healthy People is full of statistics that substantiates the cost-effectiveness . . . and it we might add . . . life-effectiveness of the health promotion philosophy. In the fall of 1980, an impressive document that outlines "Objectives for the Nation" was published by the Departemnt of Health and Human Services. It provides the direction that our nation needs to follow in developing a healthy productive population.

Our Council is currently working on a task force paper that establishes a relationship of health and productivity in the workplace. Some facts are interesting:

-Continental Bank and Trust of Chicago has experienced a drop in its turnover rate since 1974 when it enlarged its traditional occupational medicine program.

- Firestone instituted an alcohol assistance program that reaped annual savings to the corporation of $1.7 million in 1976.
- By 1978, 300 U.S. companies employed full-time fitness directors.
- Fitness Systems, Inc. reported that 15% of companies surveyed actually noted a reduction in insurance costs when fitness programs were instituted.
- potential savings and higher productivity is reflected in reduction of absenteeism, reduction of turnover, and lowered health insurance premium costs.
- Marvin Kristein, chief economist of the American Health Foundation, has calculated the potential annual savings of $347,550 per 1,000 employees for a typical American company's health care spending by its controlling and reducing chronic disease risk factors.

COST EFFECTIVE PRIORITIES

There are many programs that have proven to be cost-effective. We understand that the cost of medical care must be reduced from its present $212.2 billion spent in 1979. The top four conditions that cause death in our country are heart disease, cancer, stroke, and accidents. Considering direct and indirect costs in 1977, the cost of smoking in the United States was $27.5 billion. The cost for alcohol abuse was $44.2 billion. The cost to this country for motor vehicle accidents is placed at $24.7 billion. According to the Surgeon General, the top four conditions that cause mortality is, for the most part, preventable. Therefore, a significant amount of the costs can be prevented. The summary from the chapter entitled "The Economic Burden that Prevention Could Reduce" in Health Statistics 1980 states:

> ...a very large portion of our national health expenditures is spent on the direct health care costs of conditions for which prevention is to some degree possible. The Nation also bears a heavy burden of indirect costs from such conditions. If preventive actions were successful in cutting direct and indirect cost expenditures by only 10 percent, reductions would still equal billions of dollars.

The Health Policy Council strongly suggests that the government continue to facilitate effective health promotion programs. We are seeking assurances that whenever possible, appropriate legislative initiatives be written into the current health policy. Last year only 4% of the health care budget was for health promotion and disease prevention. We are not asking the administration to allocate additional funds into these programs. However, the funds already assigned to medical care should be reprioritized. Health promotion should received at least twice as much as the previous year. It will be effective in reducing medical care costs. Currently there is no health policy . . . only a medical care policy.

The issue raised about government regulation interfering with individual rights has been introduced as an argument for less government participation. Socioeconomic factors are powerful determinants that individuals have limited control over.

THE ROLE OF THE FEDERAL GOVERNMENT IN THE AREA OF HEALTH PROMOTION AND PREVENTION OF DISEASE

When an individual's choice infringes on the rights and and resources of other members of the community and produces a social and financial burden on the state and federal government, we believe there is a certain responsibility that must be accepted by the government. An example is the motorcycle helmet issue. Several states have repealed laws that mandate the use of helmets. This has caused as increase in mortality from head injuries to as much as double. Indeed, the individual exercises his right to wear a helmet or not. However upon injury, the use of resources, i.e. cost for medical care, becomes a burden on the rest of society. The obligation to cover extensive medical and rehabilitation costs falls upon other health care consumers.

The approach to the ethics of federal government participation is far beyond the scope of this simple testimony. It is our intention to emphasize our support that there continues to be an important role that government can play. We are asking the government to develop health promoting policy, reprioritize budget already allocated to medical care, and provide need incentives to the individual, acommunity, and private industry. A current Harris poll resulted in 92% of the respondants aggreed that health habits can prevent disease.

Some recommendations of what can be implemented are:

*DEDICATED TAX on alcohol and cigaretts that will support the care of those who are eventually treated for conditions that are caused by abuse of these two substances.

(N.B. Increased price of alcohol in United Kingdom lowered mortality from scerosis from 10/100,000 in 1915 to 3/100,000 in 1933 - a 70% decline in less than 20 years. In the U.S. in 1978, scerosis mortality was 14/100,000.)

*Third party reimbursement for programs that facilitate health promotion.

- TAX CREDIT for costs of weight reduction and stop-smoking programs for the individual tax payer.
- TAX or other FINANCIAL INCENTIVES for private industry to encourage the promotion of health in the workplace.

  1. exercise breaks
  2. employee fitness programs
  3. company physician to provide health promotion education
  4. yearly health assessment
  5. return of sick pay not used
  6. raise pension pay level when employee does not use sick days during employment career.
  7. lowered insurance premiums.

- Continue national media campaign on HEALTH PROMOTION EDUCATION.
- TAX INCENTIVES FOR HEALTH PROMOTION EDUCATION

  1. incentives for software development to educate the public consumer on health and fitness.
  2. incentives for media to allocate certain minimum time within public service announcement requirements for health promotion programs.

Our strongest point is that health promotion can make significant changes in the cost of medical care. The time is right to provide the needed incentives to change the direction of the nation's health care. There must be a health promotion component for all medical policy in place.

The Health Policy Council is an available resource to the government and would be pleased to provide more information and to participate in the decision-making process. We feel that our goals are in keeping with the present administration's goal to reduce medical costs and produce positive health results for our citizens with relatively little government involvement.

STATEMENT OF DR. R. ADAMS COWLEY, DIRECTOR, UNIVERSITY OF MARYLAND SHOCKTRAUMA CENTER, BALTIMORE, MD.

Chairman Schmitt, members of the Committee, I am Dr. R Adams Cowley, Director of the University of Maryland Shocktrauma Center, Baltimore, Maryland. I am also the director of the Maryland Institute for Emergency Medical Services Systems and the state emergency medical services director for the State of Maryland. I have been actively involved with the design, development and delivery of emergency care for 15 years. I am a member of the President's National Highway Traffic Safety Advisory Council as well as many national associations concerned with improved delivery of emergency medical services. Several years ago I founded the Mid-Atlantic EMS Council, the purpose of which is to foster complete, compatible emergency medical services systems throughout the region which encompasses the states of Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the City of Washington, D.C..

I appreciate the opportunity to share with you my views on the status of emergency medical services in this country, and based on my experience, make certain recommendations to you regarding appropriations for the EMS Act as well as EMS programs and legislation in general.

The Committee must now decide on the funding for FY 1982 for the emergency medical services program at HHS, and it is my recommendation and hope that the 30.1 million dollars recommended in President Reagan's budget be appropriated. Indeed I would recommend that the full appropriations as authorized by the extension of the EMS Act in 1979 be made so that the intent of Congress as expressed then will be carried out, that intent being that the EMS program be fully funded so that a nation-wide network of compatable systems could be completed.

In a time of frantic budget cutting and reorganization of programs, I realize that all programs before Congress must be scrutinized, and their purposed analyzed and evaluated. The establishment of priorities is essential. I think it is time, therefore to look at EMS - what the problems are that the program tries to address, what it has accomplished, and how this compares to other program requests being made for federal funds.

Every year over 10,000,000 persons are victims of trauma and require medical attention. 350,000 of these persons will suffer permanent disability. 100,000 people died last year from trauma. It is the 3rd. greatest killer in this country and the number 1 killer of people from the ages 1-40. 'Trauma' is defined as an accidental injury, and although many of these victims receive minor injury, all have needed and used some type of medical facility. The purpose of emergency medical services systems is to transform the victims of trauma into patients, by providing a means of prompt rescue, knowledgeable treatment at the scene of the accident, and transportation to a definitive medical facility.

For many years we who have worked in this field have battled to bring about better care for the trauma victim. In the past, when EMS was the sole responsibility of local communities, it was considered an ambulance program. Ambulances then did not have the communications equipment capabilities of a city taxicab service. Rescue persons rarely had the ability to administer basic life support methods; none could do advanced live support. In most people's minds as long as there was an ambulance at the fire station or at the local funeral home, and a nearby hospital that was an adequate emergency system. The public had been lulled into a false sense of security. Then in 1966 the National Academy of Sciences published a report "Accidental Death and Disability: the Neglected Disease of Modern Society", and people began to waken to the problem. The Department of Transportation began an EMS program that would address the pre-hospital rescue phases of EMS. Then in 1973 Congress passed the Emergency Medical Services Act, designed to specifically build EMS systems. The intent was and is good. But the HHS program, designed originally for 5 years and by that time to have a nationwide series of systems in place, was never adequately funded. Consequently the systems are still being developed. Partial systems, which is what we have in most areas of this country, are of little value. These systems must be completed and that means this program needs full appropriations.

It should also be mentioned that these systems could be jeopardized and millions of dollars wasted which have been spent on developing these partial systems, if we revert back to making localities solely responsible for EMS delivery. This could happen with the proposed block grant initiative.

Without some federal involvement, providing technical assistance, and quality assurance, the localities may be ill-equipped to perform the EMS responsibilities. It would be penny-wise and pound-foolish to have this national effort fall back into unorganized local control systems. It is projected that by 1985, if the present EMS Act remains in operations, our national network would be complete. In the years the federal initiative has been underway, standards of care have been implemented assuring the patient of quality care. Transportation and communications equipment are highly developed to expedite the patient to the proper medical facility. Paramedics and emergency medical technicians, who man the ambulances and begin treatment are trained in life support techniques which meet national standards. The trauma center initiative now requires hospitals to have physicians, surgeons and other specialists in-house or available when the patient arrives. Prior to 1973 it was a rare hospital that had a physician in-house 24 hours a day. This initiative for quality care through EMS systems must continue, whether the funding goes to the EMS projects via block brant or a catagorical grant.

Today, when a system is in place a victim is treated at the scene of the accident by a trained emergency medical technician or a paramedic who is capable of performing basic, and when appropriate, advanced life support care. He can analyze the victim and if needed he will receive instructions from a physician at a medical command station situated in a trauma center. The victim will then be transported to a medical center which is most appropriate to treat him. 85% of the time this will be the nearest hospital. 10% of the time the nearest facility must be by-passed and the victim taken to a regional trauma center. In the remaining 5% of the cases, the victim will be taken to a major trauma center capable of treating the most severely injured. Time is critical; a victim must receive care and be in the definitive medical center within 60 minutes; our 'golden hour'.

To those who would say we cannot afford these systems, I would invite them to consider the following. When systems are in place and operating, the chance of a victim being saved is 85%; without a system this drops to 60%. The Maryland statistics are even more dramatic. In less than 10 years, with our statewide system in place, the mortality rate has fallen from 78% to 14%. As I mentioned earlier, those who die from trauma are the young and the productive citizens. What is the value of a human life? The Department of Labor estimates an average of $287,000 per life. Last year the cost of lost productivity due to trauma was over $33,500,000,000. All costs incurred due to traumatic accidents exceeded $80,000,000,000. To those who say we cannot afford these systems, I say we cannot afford not to have these systems.

The public is slowly becoming aware of what it means to have EMS systems. This past year the book Shocktrauma, a book-of-the-month club selection in June, told a part of the Maryland EMS story. The television show "20/20" devoted a 20 minute segment on trauma centers and the unmet needs for properly treating the trauma victim. This produced over 20,000 inquiries wanting to know why this advanced care was not available in their areas. The nation witnessed the tragic fire at the MGM Grand Hotel in Las Vegas, but also witnessed an EMS system rescuing and treating victims and saw that but for the system, many of the victims would have died.

Critics of the program will say that this is a local problem and should be handled locally. This is not correct. Although the states and local communities are actively involved, and contribute $6.00 to every $1.00 of federal dollars last year for the design and operations of the EMS systems activities, this is still not totally a local issue. To be effective operationally and economically, systems must be multi-county and multi-state. Local boundaries are irrelevant in most cases. An example of this which was witnessed in the Washington D.C. metropolitan area in March, 1981, was the bus accident at Quantico, Virginia. A bus traveling from Washington D.C. to Fredericksburg, Va. went off the road, down a hill, killing and injuring many. In order to care for the injured, the facilities of the Maryland Shocktrauma Center were alerted, the Washington D.C. Hospital Center was used as well as facilities in Northern Virginia. The facilities of three states were needed to meet the requirements for caring for the injured from this accident. Another reason why systems have to cover broader areas then small localities is that they require different types of facilities. Every locality cannot afford to have a regional or major trauma center. These must be shared on a multi-county and multi-state basis due to the expense and manpower requirements. As a consequense to this, a discipline has been imposed on our health system which begins to eliminate wasteful duplication; building up centers of excellence which are economically viable. Another reason why we cannot consider this a local problem is that victims which a center or hospital treats often come from another jurisdiction. Our interstate highways bring more victims to our system than any other single source. We are a mobile society, both in our work and recreation. Possibly the Highway Trust Fund should provide dollars for our systems; but for the moment that is not happening. In the meantime our facilities are not turning away victims from outside their localities. Treatment is always given. A traveler can only hope that if he is involved in an accident it happens where there is a system in place to save him.

It should also be recognized that EMS systems are vital to our national defense and to any national disaster preparedness we wish to attain. For this nation to be adequately prepared to defend itself and its principles, an intregal part of any plan must include the capability to care for potential wounded, both military and civilian. This means we must have EMS systems in place. The same holds for disasters. When the Three Mile Island incident occurred, my institute was alerted and went into action. It was a multi-state problem and the EMS systems were vital to solving the problem.

Systems save lives. We have seen this in Maryland, where there is a statewide system (the only one in this country) and we are seeing this in our Mid-Atlantic region. Our region is developing its regional trauma centers, and the Maryland Institute continues to serve the entire 6 state region. The rest of the nation is moving, albeit slowly, in building systems. The speed with which we will proceed is linked to people and money. Money is required to build the systems; people are required to run them. For example, systems depend on thousands of persons volunteering their time and talent to serve as emergency medical technicians or paramedics. Dollars are needed to keep up training courses for these volunteers in order that they will maintain their proficiency.

The people in this nation are becoming more aware of what is available to them and demanding better care, as I mentioned before. Since appearing before this committee last year, I have established through the Maryland Institute for Emergency Medical Services Systems and the Mid-Atlantic EMS Council, a National Coalition for EMS. This will be a national voice for our cause. In addition it is my hope that a National Institute for Trauma will be established to study how to lessen the effects of trauma. For example, the cure to the effects of shock will save many of those now dying from injuries received in traumatic accidents. This is a vital need.

But for now, let us see EMS systems throughout this country, complete, operational and saving lives. Every member of this committee, every person you represent, will need an EMS system some time in his life. Many of you will need a system sometime during the next year. The question is will it be there?

The investment of dollars is low, especially compared to the magnitude of the problem it addresses. I review the budgets of the federal government and the state of Maryland annually. I never cease to be amazed at programs that receive enormous sums of money for non-life-threatening issues. In the meantime EMS receives low priority. It is as though it has been determined it is someone else's problem. Well it is not. It is a problem for us all. Unlike so many programs that require perpetual funding, EMS needs only the dollars necessary for systems to be built. Once done, the systems can become self sufficient. I can only hope that the Congress will see the wisdom of funding this program. The funds appropriated to build these systems are an investment that will yield high returns. As I said before, systems save lives. Possibly the life next needed to be saved will be one you know well.

STATEMENT OF CHILDREN'S LIVER FOUNDATION, INC.

Most people do not realize how frequently children are striken with serious liver disease. Many liver diseases are chronic, disabling, incurable and kill infants and young children at a much higher rate than leukemia, cystic fibrosis and muscular dystrophy.

The Children's Liver Foundation is a national non-profit voluntary agency incorporated in 1975 by parents of children afflicted by terminal liver disease. The three goals of the Foundation are to raise funds for basic research and clinical studies, to provide education for the lay public and health professional and to establish support systems for families of these children. Shocking numbers of infants and children are afflicted with liver disease and federal funds provided for research in this area are meager. Last year (1980) NIADDKD (NIAMDD) out of a total liver research budget of $12,000,000 and a total of 103 liver grants, provided less than $500,000 and only 5 liver grants for pediatric biliary disease research. According to the National Center for Health Statistics for every 100 deaths from Cystic Fibrosis there are 240 deaths from Biliary Atresia under the age of one year. In fact, Biliary Atresia, only one of many liver diseases in children kills more infants in this age category than leukemia and muscular dystrophy combined. Dr. John Lilly from the University of Colorado in Denver concludes from his Biliary Atresia Registry that 36% of those babies with Biliary Atresia who have corrective surgery survive until age 10, without corrective surgery life expectancy is 18 months. If corrective surgery is performed before two months the survival rate is 55% at 10 years, surgery at 2 to 3 months 46% survival at 10 years and surgery after 3 months, 15% survival at 10 years. Since the introduction of the Kasai surgery into the United States there has been a dramatic increase in the number of operations on babies with Biliary Atresia. In 1971 30% of these infants had corrective surgery, in 1974, 90% and in 1980 95%.

In 1978 Cirrhosis caused 30,000 deaths in all age groups and according to the Report of the National Commission on Digestive Diseases (1979) it resulted in an economic impact of $4.1 billion dollars.

Liver disease in children is an area which needs further investigation and support. It has been misunderstood and frequently confused as it often becomes mistakenly associated with drug and alcohol abuse. Chronic liver disease often result in irreversible scarring (cirrhosis) of the liver that often leads to liver failure and death. Presently the only hope for these children lies in liver transpantation, a program which is severely limited by inadequate funds, (cost per patient is $50,000 - $100,000) facilities and qualified surgeons. Dr. Thomas Starzl, renowned transplant surgeon, reported to the International Transplantation Society in 1980, a much improved survival rate of 91.7% after follow-up of 4 to 11 months as a result of a new anti-rejection drug therapy using Cyclosporin A and Prednisone. Previously one year survival was never increased beyond 50% and 4/5 of the deaths occurred by four months post-operatively. It appears, though it is early, that a breakthrough might be at hand. Indeed if these survival rates are maintained, liver transplantation should no longer be considered experimental but a viable and necessary life giving procedure which should be funded by the federal government in a similar fashion as kidney transplantation.

In addition the cost of maintaining a patient with chronic liver disease runs into the 100's of million of dollars in the U.S. yearly. According to the Report of the National Commission on Digestive Diseases (1980) Biliary Atresia costs $33,900,000 annually while the "total dollar impact" of galactosemia the second most common inherited metabolic defect causing serious liver damage maybe as much as $10 million per year. Proper newborn screening for galactosemia is available in 27 states and can identify those infants at risk. Simple dietary management can control and eliminate the complications of this disease.

Some important contributions to the advancement of research in children's liver diseases have already been made. How much more could be accomplished if greater sums were made available for this purpose. It is our fervent wish that these hearings will convince you to provide the funds necessary to expand research in children's liver diseases . .and help save children from its' devestating effects.

Statement of Roy H. Boyd, Chairman, Committee on Legislation, United Ostomy Association

The United Ostomy Association (UOA) is a member of the Coalition for Digestive Diseases Organization which supports the funding of health and human services programs.

The UOA has 600 chapters with a total of over 43,000 members. This includes members in every State and in Puerto Rico. We request that you support the recommendations of the Coalition for funding an information clearing house, a National Digestive Diseases Advisory Board, and basic research programs.

We believe that the information clearing house will make information more readily available to assist in rehabilitating the more than 100,000 persons estimated to require ostomy surgery (colostomy, ileostomy, or urostomy) every year. We also fully support research which may provide a cure for digestive diseases (ulcerative colitis, Crohns disease, diverticulitis, cancer, etc.) which often can be cured only by ostomy surgery.

Since most of our members have experienced the disabling effects of a digestive disease that has been cured by radical surgery, we will deeply appreciate all that you and your committee can do to support programs to cure or prevent such diseases and to rehabilitate those who must have ostomy surgery.

STATEMENT OF PETER H. VON HIPPEL, PROFESSOR OF CHEMISTRY, AND DIRECTOR, INSTITUTE OF MOLECULAR BIOLOGY, UNIVERSITY OF OREGON

I greatly appreciate the opportunity to present to you, by means of this prepared statement, my testimony as an individual citizen in behalf of the current budget request of the National Institute of General Medical Sciences of the N.I.H. I am a Professor of Chemistry and Director of the Institute of Molecular Biology at the University of Oregon, and spend most of my time in research and teaching related to molecular aspects of the function and regulation of the processes of heredity and development. In addition I have served on study sections and ad hoc peer review groups of the N.I.H., and so am very familiar with the strengths and effectiveness of this methodology of administering federal research and research training support. My curriculum vitae and bibliography are attached to provide you with further information on my background and experience in basic biomedical research.

The Congress has charged the National Institutes of Health with the responsibility for funding and overseeing the national effort in biomedical research, and there can be no question that this effort has been overwhelmingly successful. Significant advances in the control of many diseases, leading to longer and healthier lives for our citizens, have resulted. Some of this progress has followed from the application of therapeutic techniques developed on the basis of empirical trial-and-error clinical experiments and random observations, but it is clear that the primary engine of the majority of this progress has been our nation's enormously successful program to understand the molecular mechanisms of the basic cellular processes. The support and orderly funding of this program of research has been the prime responsibility of the National Institute of General Medical Sciences, and the NIGMS has discharged this responsibility extraordinarily well.

A few examples from my own general area of research will suffice to illustrate the close connection (which is almost always evident only in hindsight) between basic research and practical consequences directly related to human health. The most successful basic research programs are almost always conceived by individual investigators, and are motivated by an intense curiosity about the molecular laws and mechanisms underlying biological phenomena. Thus a large part of the background biology which has made possible our present understanding of virus-induced cancers developed from experiments designed to investigate the mechanisms used by totally disease-unrelated viruses called bacteriophages to attack, integrate into, and modify their bacterial hosts. The development of the entire field of genetic engineering, which promises such rich dividends in the increased production of pure hormones, enzymes and antibiotics for use by the medical community, was made possible by the discovery of restriction enzymes, which again first manifested themselves in terms of the behavior of certain bacteria which somehow seemed to acquire resistance to attack by certain phages. The molecular basis of sickle cell anemia was discovered in the course of basic investigations on amino acid sequences in hemoglobin chains, and therapies for it are now being designed in terms of discoveries on the molecular nature of protein-protein interactions, and how these interactions can be altered by changing the solvent environment.

Experience has overwhelmingly shown that the most direct (and most economical) path to medical advances lies in the orderly development of our understanding of basic biological principles. Often the clinical exploitations of this understanding, and its most glamorous applications, comes through applied clinical research which is generally funded by the categorical (disease-related) Institutes of the NIH. But none of this would be possible without the continued uncovering of basic principles, which is now proceeding at an explosive rate. This impetus must be continued, or eventually the whole complex of medical progress and application which depends on it will slow down and stop. In my opinion two conditions must be met to insure its continued progress:

(1) Funding must continue to be made available for the support of the best basic research proposals submitted to the NIGMS. These proposals are subjected to rigorous screening by peer review groups made up of working scientists, and this system of evaluating proposals has been widely acclaimed as the fairest and most productive of high quality research of any procedure which has been devised anywhere. To keep this system healthy and working well, and to keep from losing bright established investigators and productive research teams, I believe that

the NIGMS should be provided with sufficient resources to fund the top 30 to 50% of approved investigator-initiated research grants on a continuing basis.

(ii) The second critical element is the continuation and strengthening of the basic research training programs of the NIGMS, through both individual research fellowship and institutional research training support. Many of the most innovative and seminal discoveries of basic molecular and cellular biology over the last twenty-five years have been made by young investigators developed and nurtured by NIGMS-funded research training programs. These training programs must be supported and expanded to make it possible to continue to attract and train new investigators in these fields. Until recently, the positions available to such young investigators have been largely confined to university and government departments and laboratories; the recent and explosive development of biotechnology in the private sector now offers entirely new types of positions to trained young investigators, and it is essential to maintain and expand research training opportunities and programs now in order to have trained investigators available when the clearly foreseeable needs for such people are fully upon us. Post-baccalaureate training in molecular and cell biology is a six- to eight-year process, and the mechanisms for providing such training (primarily again through the NIGMS) must be maintained and strengthened now.

One area in which cuts are currently under consideration which I think would be very counter-productive, is the proposed decrease or elimination of institutional allowances and overhead payments in connection with federal fellowships and training programs. Such cuts would make it still more difficult for hard-pressed "trainor" institutions to provide the necessary facilities and support for their trainees and training programs. The concurrently proposed cuts in the numbers of trainees would have even more deleterious consequences. It seems to me crucial, in view of the increased needs and opportunities for new investigators as outlined above, that the number of trainees be held constant, or increased if possible.

A healthy program of basic biomedical research is essential to continuing advances in the control of disease. Maintaining such support at a level necessary to compensate for cost inflation, and to permit finite levels of research and training expansion even in this time of wide-spread budget-cutting, seems to me to be necessary from both a humanitarian and an economic point-of-view. A physically and mentally healthy citizenry is one of the most important, and ultimately cost-effective, objectives to which a nation can aspire, and continued and successful basic biomedical research represents an important route to that goal.

Thank you very much for the opportunity to present this prepared statement as a citizen witness in behalf of the NIGMS budget.

CURRICULUM VITAE

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EDUCATION:

1952	B.S., Massachusetts Institute of Technology
1953	M.S., Massachusetts Institute of Technology
1955	Ph.D., Massachusetts Institute of Technology

HONORS AND/OR PROFESSIONAL EXPERIENCE:

1953	Research Assistant, Department of Biology, Massachusetts Institute of Technology
1952-1955	National Science Foundation Predoctoral Fellow
1955-1956	Research Associate, Department of Biology, Massachusetts Institute of Technology; National Heart Institute Postdoctoral Fellow
1956	Guest Scientist, Physical Biochemistry Division Naval Medical Research Institute, Bethesda, Maryland
1956-1959	Physical Biochemist, Naval Medical Research Institute, Bethesda, Maryland
1959-1961	Assistant Professor of Biochemistry, Dartmouth Medical School; Senior Research Fellow USPHS (now Career Development Award)
1959-1967	Senior Fellow (subsequently Career Development Awardee) National Institutes of Health
1961-1967	Associate Professor of Biochemistry, Dartmouth Medical School
1963-1967	Member, Biophysics and Biophysical Chemistry Study Section, USPHS
1965-1967	Acting Chairman, Department of Biochemistry, Dartmouth Medical School, Hanover, New Hampshire
1966-1970	Member, Editorial Board, Biochimica et Biophysica Acta
1967-present	Professor of Chemistry and Research Associate, Institute of Molecular Biology, University of Oregon, Eugene, Oregon
1968-1973	Member, Editorial Board, Journal of Biological Chemistry
1968	Chairman, Biopolymers Gordon Conference
1969-1973	Council Member, Biophysical Society
1969-present	Director, Institute of Molecular Biology, University of Oregon, Eugene, Oregon
1972-1977	Member, Editorial Board, Physiological Reviews
1973-1974	President, Biophysical Society
1973-1974	Guggenheim Foundation Fellowship
1973-1976	Member, Trustees Visiting Committee for Department of Biology, Massachusetts Institute of Technology
1974-1978	Member, Board of Scientific Counselors, National Institutes of Arthritis, Metabolic and Digestive Diseases, NIH
1976-present	Member, Editorial Board, Journal of Biological Chemistry
1977-present	Member, Editorial Board, Biochemistry
1978-present	Member, National Academy of Sciences
1979-present	Fellow, American Academy of Arts and Sciences

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A.A.A.S., A.A.U.P., Am. Chem. Soc., Am. Soc. Biol. Chem., Biophysical Soc., Fed. of Am. Sci., Sigma Xi, Soc. of Gen. Physiol.

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Peter H. von Hippel

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STATEMENT OF DR. EDWARD CARELS, VICE PRESIDENT OF COMMUNICATIONS, COMPREHENSIVE CARE CORP., NEWPORT BEACH, CALIF.

Thank you for the opportunity to comment on the proposed budget for the Alcohol, Drug Abuse and Mental Health Administration.

I am Dr. Edward Carels, Vice President of Communications for Comprehensive Care Corporation, a nationwide health care management organization. We operate the nation's largest private network of inpatient alcoholism treatment programs for adults and adolescents through our own freestanding hospitals and contract units - CAREUNITS - in community hospitals. Additionally, we own and operate acute psychiatric hospitals and manage short-term psychiatric programs - STRESSCENTERS - in community hospitals. More than 27,000 people are treated each year in our facilities. Other services of our company include free community counseling and referral services; workshops and seminars for health care professionals through CareInstitute; consultation on employee assistance through our PACE program, and the publication of growth-centered literature.

Because of our commitment to prevention and treatment of substance abuse and mental illness, we believe our data and recommendations from the private sector might assist you in determining which budget appropriations are cost effective and literally, life savers, since these illnesses when untreated often result in premature death or insanity.

The dilemma you face requires some of Solomon's wisdom. Alcoholism, drug abuse and mental illness have been identified among our nation's greatest health problems by numerous organizations, including the Centers for Disease Control, Veterans Administration, American Medical Association and the White House Conference on Families.

Approximately 15 percent of our nation's people suffer from mental disorders and problems with alcohol or other drugs severe enough to require treatment. At least, 14.1 million Americans are problem drinkers or alcoholics, yet 85 percent of them receive no formalized treatment. In 1979, the National Survey on Drug Abuse revealed that 13 percent of the U.S. population is regularly using marijuana, 4 percent is using inhalants, hallucinogens, stimulants and PCP and 2 percent is using cocaine. Additionally, there are millions of people abusing sedatives and tranquilizers.

These illnesses cost this country billions of dollars - $61 billion annually for alcohol-related problems; $15 billion annually for drug abuse; and $44 billion annually for mental illness. For alcohol abuse alone, this nation loses:

- $28.0 billion in Lost Production
- 18.1 billion in Health and Medical Services
- 7.3 billion in Vehicle Accidents
- 4.1 billion in Violent Crime
- 2.7 billion in Welfare Costs
- .6 billion in Fire Loses

The human costs are staggering as well. More than 10 percent of all deaths in the United States are alcohol or other drug-related.

That we have problems of epidemic and monumental proportions is undeniable. But at the same time, the Executive Branch is saying Americans must "accept cuts in virtually every branch of government if the nation is to avoid economic calamity," and the Legislative Branch is taking action to meet the national mood of fiscal restraint. Recognizing that some costs must inevitably be made, the issue then is where will the cuts do the least damage.

The National Institute on Alcohol Abuse and Alcoholism, the National Institute of Mental Health and the National Institute on Drug Abuse - all provide valuable services in the areas of research, training, education and information dissemination, prevention and treatment.

Their jobs are not getting any easier. Alcoholism is growing at a rate of 250,000 new cases annually. More and more people are abusing drugs and at younger ages. The number of young people ages 18 to 25 having ever used hallucinogens, cocaine, heroin and the like climbed from 3 percent in 1962 to 33 percent in 1979, and the number of young people having ever used marijuana climbed from 4 percent in 1962 to 68 percent in 1979. We know that some 5 million Americans suffer from schizophrenia, depressive illnesses and organic psychoses and about 25 percent of the population is estimated to suffer from anxiety, depression and other indicators of emotional problems.

One of the key factors in reducing the incidence of substance abuse and emotional problems is research. Comparing the current operating budgets of the Institutes with President Reagan's proposed changes for FY 1981, we note that appropriations are being reduced - NIAAA from $22.3 million to $21.7 million; NIMH from $152 million to $143 million; and NIDA from $46 million to $45 million.

We urge expanded research efforts into the etiology, prevention, treatment and consequences of these diseases, and consequently, we favor increased appropriations. We concur with NIAAA's research targets of occupational alcoholism, women, youth, Fetal Alcohol Syndrome and domestic violence and would recommend increased efforts in identifying causal factors of alcoholism, early identification methods, such as blood alcohol levels, and sobering agents. The nine Alcohol Research Centers add immeasurably to data on the causes of alcohol problems and social consequences, while also providing continuing education programs for professionals in the field. Some of our treatment teams have updated their knowledge and skills by attending the Centers' seminars.

For NIDA, we would particularly support exploration of new drug abuse treatment methods for the polydrug abuser. And for NIMH, we particularly support the research initiatives on adolescents and the elderly.

But all the research in the world is of no value unless it gets into the hands of people who can apply the results in a treatment setting. It is noteworthy that much research does not change the way alcoholism and substance abuse are treated. Information dissemination is a key service provided by all three Institutes, and we would hope that the information to be provided for publication of reports, such as the Fourth Special Report to the U.S. Congress on Alcohol and Health, continue to be funded but with more emphasis on making employers the target for such information. Employers can motivate the worker to seek help.

These illnesses are unusual in that the victims usually do not think they have a problem, will deny they have a problem and will not seek help unless strongly urged to do so. The employer, with the power of the paycheck, is in an excellent position to see that the sick individual gets the help he or she needs. And we know that the earlier an individual is treated, the greater the chances for recovery. The employer also determines what benefits are covered under insurance.

Prevention and early detection of substance abuse or mental illness results in substantially reduced health care costs, societal costs and lost lives. We would particularly urge funding for prevention programs aimed at the mass media and the workplace. We have found in our own use of mass media through guest spots on talk shows, public service announcements and paid television commercials, you can raise the public's awareness of substance abuse and mental illness problems and motivate family members to get the sick person into treatment.

Another critical factor in getting the substance abusers and emotionally ill the help they need is having people who know how to identify and treat them. Under the proposed FY 1981 and 1982 budgets, the amounts designated for training drops for all three Institutes. For NIAAA, training allocations would drop from present levels of $5.8 million to $4.5 million by FY 1982. For NIMH, the costs are deeper - from the present $93.8 million to $59.1 million in FY 1982. And for NIDA, funding would drop from the present $7 million to $6.5 million in FY 1982.

Adequately trained health care professionals are the link between the need and the solution. The American Medical Association has called for increased training in medical schools in the areas of substance abuse. The President's Commission on Mental Health pointed out that many mental health facilities have a shortage of trained personnel, particularly those who can work with children, adolescents and the elderly. The Institutes have contributed greatly to the training needs of this country by encouraging uniform standards for credentialing professionals, by funding career teacher posts in substance abuse at 62 medical schools, and by developing curriculum guides for health care professionals.

The need for training can be exemplified in the alcoholism field. It has been our experience that many physicians fail to diagnose alcoholism in patients they have treated for many years, because they are treating a complication of alcoholism, such as ulcers, rather than the illness itself. We would urge funding levels for training to remain at current levels for alcoholism and substance abuse problems.

Research, information dissemination, targeted prevention efforts and training are the areas which we believe the federal government can make the greatest contribution toward reducing the problems of substance abuse and mental illness. In the interest of fiscal restraint, we would see the budget cuts coming in the areas of overseas travel and project expenditures, administrative support services, unproductive prevention efforts, and treatment.

During 1980, more than 3.6 million people received treatment in ADAMHA-assisted programs - 276,000 through NIAAA grants; 227,000 through NIDA, and 3,100,000 in NIMH-supported community mental health centers. We believe the private sector is able to initiate effective treatment programs for all citizens. We support Reagan's proposed cuts in service allocations from $73 million to $70.7 million for NIAAA, $324 million to $285 million for NIMH and $161 million to $160.2 million for NIDA. The remaining treatment monies are best spent for specialized programs to service those outside the mainstream of health care, such as the indigent and minorities, for diverting public inebriates from the criminal justice system to treatment; and for experimental programs investigating new treatment approaches. Once proven effective, such innovative programs should be encouraged to reach the status of self-sufficiency and duplicated throughout the country.

The block grant concept proposed by Reagan for FY 1982 for funding treatment may indeed reduce service duplication and program overhead costs. But we are somewhat concerned that placing alcohol, drug abuse and mental health treatment programs in competition with other more "socially acceptable health programs" may jeopardize their existence. Substance abuse and mental illness are stigmatizing illnesses which have been excluded from the mainstream of care for many years. It is unlikely they will be accorded the same priority as other diseases at some state levels.

Still, the private sector can assume a greater load of treatment for the majority of people. The areas we would encounter some difficulty would be for treatment of indigents (although our company and others do provide charity beds in our facilities) and for some minorities where cultural expertise is a necessity.

There are private treatment programs ready for implementation across the country, but they are being delayed because of the Certificate of Need process. In our own case, we have 32 programs for the substance abuser and emotionally ill which could be opened immediately, except that we have been waiting an average of 9 months to two years for approval of the Certificate of Need. These delays translate into some 12,000 people not being treated in a year's time.

Substance abusers and the emotionally ill are already being treated in hospitals for the medical complications of their illness. Thus, the need for substance abuse treatment and the psychiatric care are often obvious. Implementation of inhospital programs which utilize empty beds require little capital expenditure (usually no more than $25,000). Given these two factors the Certificate of Need is usually ultimately approved anyway.

If you multiply our experience by that of several other private providers of treatment, you have some idea of the potential treatment reservoir we have in this country. To tap that reservoir only requires the elimination of the wasteful, costly, and inhibitory Certificate of Need process for the areas of substance abuse and psychiatric care when little or no capital expenditures are involved.

Our comments about the Certificate of Need should not be construed as an attack on all health planning. We support the concept of health planning. But we do not feel that the Certificate of Need process has worked effectively for hospital-based alcoholism-treatment and psychiatric care.

We use existing hospital beds and feel it is the best and most cost-effective use of the empty beds. Additionally, alcohol and drug abusers in the later stages of addiction and individuals experiencing a major psychiatric crisis need the close monitoring and expert care provided in a hospital environment.

We support the recommendation of Dr. Harry Cain, executive director of the American Health Planning Association, who suggests that projects which do not exceed $500,000 in capital expenditure not be reviewed under the Certificate of Need process.

A stimulus to the private sector to fill the treatment gap could come also from increasing insurance coverage for alcoholism, drug abuse and mental illnesses to a level comparable with other illnesses. Health care prices are out of reach for many average wage earners. Without insurance, many persons cannot afford needed treatment.

Great strides have been made in the last decade in securing limited coverage of alcoholism and mental illness. There needs to be expansion of coverage particularly in the area of drug abuse, and more uniformity in coverage. While the research studies of NIAAA. NIDA, and NIMH are helpful, providers in the private sector can best negotiate with the insurance industry on benefit expansion. They have the practical knowledge that comes with treating patients who have to submit insurance claims.

Once the barriers of stigma, health planning and inadequate insurance coverage are reduced, the private sector can move swiftly to implement needed treatment programs. And the NIAAA, NIMH, and NIDA can concentrate on what each does best - research, information dissemination, prevention, training, and experimental treatment programs.

STATEMENT OF ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA, INC.

The Administration has requested the rescission of FY 81 appropriations for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of $53.2 million or 32.7% of its current budget; and, for the National Institute on Drug Abuse (NIDA), of $32.2 million or 13.1% of its budget. On behalf of its membership of approximately 10,000 professional workers in the field of alcohol and drug abuse -- and of the thousands of clients in communities across the country receiving services at any given time as a result of this funding -- the Alcohol and Drug Abuse Problems Association urges the rejection of these requests.

The major programs recommended for termination under the rescissions are the State Formula Grant Programs of the two Institutes. $50 million is to be rescinded from NIAAA and $30 million from NIDA. Because all of these funds are transferred directly to them, the states and the community-based programs they support will be the actual losers should the FY 81 appropriations be rescinded.

Contrary to the belief of some, the planned utilization of FY 81 appropriations would have occurred prior to the beginning of FY 82 in many states. A spot check of just a few states indicates the following:

- Illinois would commence using FY 81 funds in April, 1981 for drug abuse programming. In this regard, over 50% of the state's administrative budget would be eliminated with over one-half of the state employees having to be terminated in May. State toxicological services, now provided free of charge to drug abuse programs, would be eliminated. Involved is $671,660 or one-half of the rescinded drug abuse funds which would cover April-September, 1981.

- Iowa, effective in April, will reduce contracted support to programs by 25%. Forty-five percent of the state office staff have already received employment termination notifications to be effective April 23rd. Like Illinois, Iowa is six months behind cycle in utilizing federal formula grant funds. Involved is $503,031 or one-half of the rescinded alcohol and drug abuse funds which would cover April-September, 1981.

- Kentucky as of July 1 will have to terminate 33 programs presently providing services to over 8,000 clients annually. Over 100 staff positions across the state would be lost. Eleven non-hospital detoxification facilities would be among the programs eliminated, as would specialized programs for women, racial minorities, the elderly and youth. This would occur in a context where the state is in the process of reducing alcohol and drug abuse services by $500,000 due to a state deficit. Involved is $332,168 or one-quarter of the rescinded alcohol and drug abuse funds which would cover July-September, 1981.

- Michigan also utilizes state formula grant funds about six months after the beginning of a fiscal year. Effective in April, there will be a loss of 150 service providers statewide and a 12% cut in state staff. Services for approximately 10% of an increasing client base would be discontinued. This is occurring in the context of a 10% cut in state funding in September, 1980, and another 10% cut in January. Involved is $1,551,006 or one-half of the rescinded alcohol and drug abuse funds which would cover April-September, 1981.

Alcohol and drug problems are undoubtably America's primary public health problem. Together, they are estimated to cost the country $65 billion in direct, measurable losses, mostly in terms of reduced productivity. Costs in terms of destroyed families, increases in violent crime, reduced preparedness among our armed services etc. are not easily measured, whether in terms of dollars or of human suffering.

It should be emphasized that it does not make sense economically to treat alcohol and drug abuse as minor problems. Still, this $65 billion a year situation has been grossly underfunded at the federal level in years past. Even the $80 million proposed for rescission, when contrasted with the $65 billion price tag, represents a ratio of 1 to 800.

The Alcohol and Drug Problems Association urges the subcommittee to retain funding for alcohol and drug abuse for FY 81 at those levels voted by Congress in the continuing resolution presently in force. The need of the American people for these services is hardly less than it was several months ago when the resolution was passed. The value to the economy of sober, drug-free employees continues to be plain to see and understand.

STATEMENT OF MRS. EUNICE KENNEDY SHRIVER

Mr. Chairman, I would like first to thank you and the distinguished members of the Subcommittee for extending to me and others this opportunity to share our knowledge and views with regard to adolescent pregnancy and the Federal Government's activities concerning it.

To do something helpful about teenage sex and pregnancy, we do not need more money for the mechanics of birth control or more value-free sex education. We need efforts that strengthen family commitment and marriage and get at the problems that lead adolescents into early sexual activity. Such activity arises not only from lack of information or equipment, but also from loneliness, peer pressure, family rejection, and from a free market system that sells products through sex. Teenage pregnancy results from an overwhelming need to be loved and part of a family, from a desire to express one's maturity and independence, from the normal human desire to do something important and be someone special. None of these human needs are fulfilled by birth control.

Nearly one million adolescents become pregnant every year — despite hundreds of millions spent on thousands of birth control clinics. Of these, more than 500,000 teenagers decide to give birth because, as many say, "I want someone to love and to love me."

To be sensitive to the fundamental human needs involved in teenage pregnancy, one must be concerned with two goals: nurturing of caring relationships among parents, their children, and members of the extended family; and emphasizing and supporting marriages that endure.

Through a program which Secretary Schweiker's department already supports, the Adolescent Pregnancy Program, teenagers can get help to face their sexual lives with maturity, knowledge, and a sense of personal responsibility. The program, which is funded for only $10 million, provides grants to establish and maintain centers for pregnant teenagers and their families. These centers have been created and are supported by public and private financing. They are located in schools, hospitals, communities and rural settings. They are not family planning clinics.

Sex education and birth control services in such centers are not regarded as enough by themselves to meet the many moral crises which teenagers face. Instead feelings of personal respect and personal responsibility are developed along with a better sense of the importance of nutrition, health, education, job reliability, and parenting. These centers provide ways of helping adolescents be better parents without encouraging more to become parents. These centers are a place where neighborhood volunteers provide continuous assistance and assurance. These centers are far more than a health-delivery system: they are a human-life-support effort on behalf of mothers and children, and hopefully their families.

Where these new "communities of caring" exist, repeat pregnancies can be cut by almost two thirds; welfare dependency can be greatly reduced; and the incidence of child abuse can be vastly diminished.

Why this success? Because in these programs we have learned that family involvement is the key to motivating teenage mothers and fathers to stay in school, to get off drugs and alcohol, to maintain physical and emotional health, and to take control of their lives. We have learned that we must go beyond technical questions of caring for the pregnant woman and the physical needs of the baby. A successful program must address as well the moral problems these young men and women face and the virtues they will need to face them -- a capacity for patience, love and trust; a measure of courage in the face of great odds. Sexual education need not be thought of nor presented only as a prevention of babies born. Unfortunately in the past it has often been so regarded, or as a means to reduce a population, or to reduce costs to society, or to "free" women from "the drudgery" of being "only" wives and mothers. Sex education, however, can be used as a means of encouraging reflection on the eternal questions of human life: -- of marriage, of responsibility, of work, the prevention of harm to the fetus, the duty to care for one's body and to be proud of it, the need for courage and endurance in nuturing a baby, the need to respect ourselves, and to set examples of virtue for our children.

In FY 1981, the Office of Adolescent Pregnancy Programs is operating under a continuing resolution at a level of just under $9 million. I would like to recommend to the Subcommittee that the Adolescent Pregnancy Program be funded in FY 1982 at a minimum of $10 million.

Why should this relatively small and new program be continued?

- Comprehensive adolescent care pregnancy programs have demonstrated 75-90% reduction in school dropouts, second pregnancies, and welfare enrollment.
- Comprehensive adolescent pregnancy care programs are the only alternative to abortion available to many young women.
- The present funding level is necessary to maintain even a few models to serve as cost effective demonstrations of care.
- Comprehensive adolescent care pregnancy programs have demonstrated major reductions in expenditure of Medicaid entitlement funds by preventing premature births. A demonstrated reduction to half of low birth weight rates saves Medicaid hospital charges for intensive newborn care equal to the cost of the whole program.
- Comprehensive adolescent pregnancy care programs must be given sufficient time to serve as models for state, municipal, and private support or adolescent pregnancy will again go out of control with escalating costs for society.
- Some bureaucrats may claim that their programs provide similar services, but the facts are that they do not have a major programmatic initiative for comprehensive care of pregnant adolescents.

Those who form the centers for adolescents and their families have important ethical responsibilities toward them -- to treat them not as "problems," but as human beings with social, intellectual, emotional, and spiritual dimensions which need expression and development; to help them have faith and hope that love and family can be a great good in their lives. The young mothers and fathers and their families will be faced with an unfolding series of practical choices that in fact depend on their ethical values. Whatever the question, -- whether it deals with nutrition, getting along with one's parents, determining to stay in school, looking for a job, arranging for good child care, working out money problems, and thinking through questions of family planning and development -- these questions cannot be separated from ethical values. The Office of Adolescent Pregnancy Programs' effort seeks to strengthen the bonds of love between parents and children, brothers, and sisters, husbands and wives, and between members of the community who can give love and caring when they are lacking in the lives of their adolescent sons and daughters.

In the face of attitudes and customs that have dealt coldly and harshly with adolescent mothers and fathers, and their babies, this program attempts to bring about a reconciliation, a recognition that those at risk, those in need, are our neighbors, and that we owe our neighbors the love and caring that are ingrained in every cultural and religious tradition we value.

Pregnancy is traumatic enough when everything goes smoothly and reassuringly. But for the most part these teenagers are too young, the occasion on which they got pregnant probably unsanctioned, the father perhaps immature or altogether absent, and the young people's own families in a state of disarray, torn by conflict, anger and a long history of defeat and sadness.

No matter their troubles and conflicts now, these adolescents and their families are worthy of our best efforts, our confidence, and our love. The consciousness of America can be raised concerning the moral, emotional, and phychological needs of teenagers. Only when this happens will teenagers themselves be able to understand and practice those values of respect, responsibility and concern for consequences which are the only _truly_ effective answer to too-early pregnancies.

This is not a vain or empty hope. The Adolescent Pregnancy Program is dealing effectively with the most alienated, most difficult to reach of these young people. Many medical institutions are involved. Schools are involved in many communities. Increasingly, doctors, nurses, teachers, clergymen are becoming involved. The parents of the young girls — and the _fathers_ of their babies — are being brought in as part of the process of sharing values and learning trust. There are strong indications that these programs are working. The girls _do_ have healthier babies. They more frequently _do_ form stable families. A greater proportion _does_ go back to school and get jobs. A much smaller proportion _doesn't_ get pregnant again. And what they learn and experience has been seen to have a ripple effect among their peers so that "primary prevention" is actually encouraged and practiced.

This is where public policy should be taking us. President Reagan's and Secretary Schweiker's emphasis on family responsibility must be translated into programs that shift our priorities from the mechanical to the moral; from the bureaucratic to the familial; from reliance on transitory adolescent notions of sexuality to the timeless values of love, marriage, and commitment to the creation of strong and enduring families.

Such programs should be expanded in numbers and influence. Through them we can create a happier society for teenagers and ourselves.

I ask that you think of this program as an essential part of our national commitment to family-building and family-renewal; to the creation of a physical, emotional, and spiritual environment in which the birth of a child and the creation of a family are treated with the respect and reverence they deserve.

This troubled, fragile, yet most indispensable of all our human resources is yours to protect. I ask for your wisdom and your compassion.

Thank you.

STATEMENT OF MS. LINDA M. STERN, DIVISION OF CHILD HEALTH, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, N.Y.

- Sixteen percent (16%) of the 14,637 teenagers who gave birth in New York City in 1978 had had NO PRENATAL CARE AT ALL. Thirty six percent (36%) had had late care or none.
- Similarly, in every other county in New York State, pregnant adolescents had less prenatal care and received it later than any other age group.
- New York's ten Upstate counties with the highest incidence of live births in women UNDER 17 years of age were predominantly rural and had the least resources for these young women.
- The same is true for the ten counties with the highest incidence of live births in women aged 17 through 19.
- Inner-city areas have the poorest outcomes of pregnancy, primarily in the young.

Adolescence, non-availability or non-accessibility of services, poverty, and under-utilization of services available by poorly motivated and frightened youngsters go hand in hand. They make the care of pregnant teenagers and their offspring a problem that needs much, much more than the routine, impersonal handling by the "system." These youngsters are indeed the ones most likely to fall through its cracks.

There are agencies to help a pregnant adolescent: WIC, counselling centers, social service agencies - but SHE must seek them out herself and then submit to the red tape. What 13 year old can deal successfully and fearlessly with this bureaucratic process? Few, if any; it even turns off the adults!

The system is too formidable for her to tackle on her own, and more often than not she has no advocate. So she simply does not try, or tries once and gives up out of fear and an inability to cope. Her family may try to help, but even under the best of circumstances, relationships are strained BECAUSE of the pregnancy. Communications may break down, and even families who want to help find they cannot cope. Many a youngster under these circumstances runs away or, worse yet, is turned out BY THE FAMILY. Parents are often as confused as the youngster, and they need help, too!

Eunice Kennedy Shriver has called the program funded through the Office of Adolescent Pregnancy Programs (OAPP) "communities of caring." It is an appropriate designation. Caring takes the form of giving special, individual attention; linking with the family and community agencies to coordinate the services for these youngsters, thereby making it easier for them to negotiate the barriers and, at the same time, preventing duplication. This "community of caring" is springing up everywhere a new program is introduced, - as is happening in our North country - and a network results encompassing private doctors, family, consumer education groups, well-baby clinics, schools, etc. able to offer and coordinate the needed services and meet individual family needs. It is a manageable system, even for a 13 year old!

Caring takes the form of providing, in an ONGOING, individual manner, in a non-judgmental, non-punitive environment, extended family assistance and other family-oriented services in order to assist the young woman, strengthen family ties, and support the entire family through a difficult period.

By helping to build family support systems for non-pregnant and pregnant adolescents and adolescent parents, OAPP programs immeasurably lessen the chance that these youngsters will fall prey to inertia and despair, and become just so many more nameless, faceless women on the welfare rolls!

Caring takes the form of helping these young women - and their families - realize the importance of completing their education so they can compete in the job market, and become self sufficient and proud of their accomplishments.. Caring takes the form of following up on a referral to ensure an appointment is kept, a service is provided. Few social service providers today have the time or the money to follow up a client, no matter how much they would like to. The result? No one will ever know in that case. But OAPP programs do know through close follow-up of each client. OAPP programs are vitally needed BECAUSE they are "communities of caring."

In FY 1981, OAPP received 380 grant applications requesting funding of $101 million. In New York State alone, 60 community agencies applied in order to establish a "community of caring". Only 3 could be funded.

The need is enormous and I urge you to fund the OAPP program at twice its current level of 7.5 million. Only then can a national impact begin to be made.

LIVE BIRTHS
Rate/1000 Females 17-19 Years of Age

1978
Upstate New York, Ranked by County

County	Rate/1000 Females	Rank	County	Rate/1000 Females	Rank
Orleans	82.2	1	Livingston	52.4	30
Steuben	81.8	2	Seneca	51.8	31
Franklin	78.9	3	Yates	51.7	32
Allegany	76.9	4	Sullivan	51.4	33
Schuyler	76.6	5	Madison	50.8	34
Wayne	76.3	6	Greene	49.4	35
Oswego	74.7	7	Hamilton	49.3	36
Lewis	72.1	8	Rensselaer	49.1	37
Jefferson	69.5	9	Saratoga	46.8	38
St. Lawrence	68.1	10	Onondaga	45.9	39
Chemung	66.4	11	Erie	45.9	40
Clinton	65.8	12	Orange	45,0	41
Cattaraugus	65.1	13	Ontario	43.5	42
Cortland	64.2	14	Schoharie	42.6	43
Washington	64.0	15	Albany	42.5	44
Genessee	62.1	16	Broome	42.1	45
Cayuga	61.6	17	Monroe	39.6	46

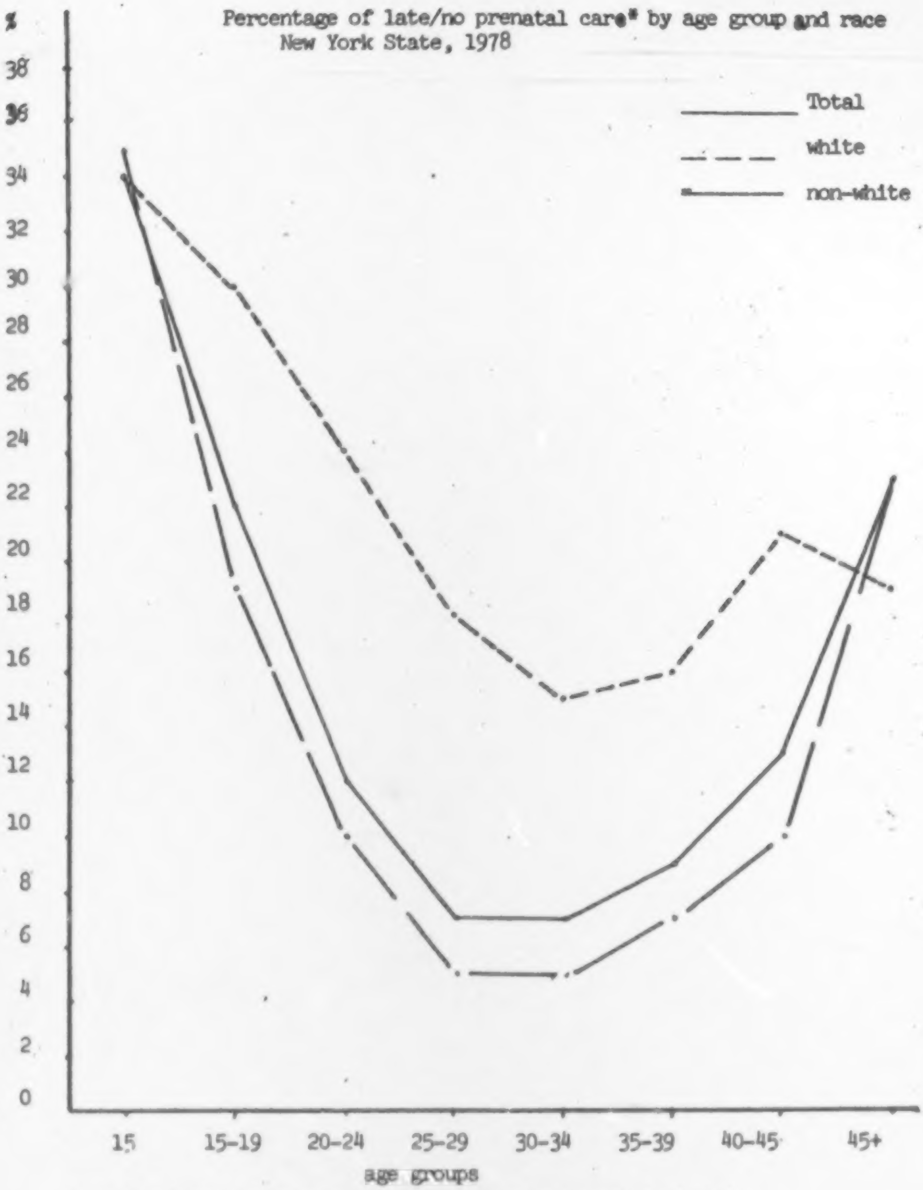
County	Rate/1000 Females	Rank	County	Rate/1000 Females	Rank
Essex	60.9	18	Otsego	36.4	47
Chenango	60.6	19	Schenectady	35.2	48
Wyoming	60.2	20	Ulster	34.9	49
Tioga	60.0	21	Columbia	33.3	50
Chautauqua	59.7	22	Dutchess	32.4	51
Fulton	59.3	23	Tompkins	30.1	52
Warren	59.1	24	Suffolk	25.2	53
Herkimer	59.1	25	Westchester	23.6	54
Oneida	58.3	26	Rockland	21.3	55
Montgomery	55.0	27	Putnam	20.0	56
Niagara	54.9	28	Nassau	14.7	57
Delaware	52.4	29			
Upstate Total				39.0	

LIVE BIRTHS
Rate/1000 Females <17 Years of Age

1974-1978 Averaged
Upstate New York, Ranked by County

County	Rate/1000 Females	Rank	County	Rate/1000 Females	Rank
Orleans	13.1	1	Genessee	8.1	30
Wayne	13.0	2	Schuyler	7.9	31
Washington	12.5	3	Columbia	7.8	32
Clinton	11.6	4	Ontario	7.7	33
Cattarugus	11.5	5	Livingston	7.6	34
Monroe	11.0	6	Herkimer	7.5	35
Madison	10.9	7	Seneca	6.9	36
Jefferson	10.8	8	Onondaga	6.8	37
Essex	10.7	9	Greene	6.7	38
Oswego	10.2	10	Broome	6.0	39
Warren	10.2	11	Rensselaer	6.0	40
Lewis	10.1	12	Saratoga	5.8	41
Allegany	10.1	13	Otsego	5.4	42
Steuben	10.0	14	Delaware	5.4	43
Niagara	9.9	15	Dutchess	5.3	44
Franklin	9.8	16	Montgomery	5.2	45
Oneida	9.7	17	Schenectady	5.2	46
Fulton	9.6	18	Schoharie	5.1	47
Erie	9.5	19	Ulster	4.9	48
Wyoming	9.4	20	Tompkins	4.9.	49.5
Albany	9.1	21	S.Lawrence	4.9	49.5
Chautauqua	9.1	22.5	Suffolk	4.7	51
Cayuga	9.1	22.5	Westchester	4.3	52
Tioga	8.9	24	Hamilton	3.5	53
Chemung	8.7	25	Rockland	3.1	54
Sullivan	8.7.	26	Nassau	2.8	55
Orange	8.5	27	Putnam	2.7	56
Cortland	8.2	28	Chenango	2.5	57
Yates	8.1	29			

Several rates appear tied but are actually different when carried to more than one decimal point.



Percentage of late/no prenatal care* by age group and race
New York State, 1978

* in the third trimester of pregnancy. unknown not included.

Source: Vital Statistics of New York State, 1978, Table 7.

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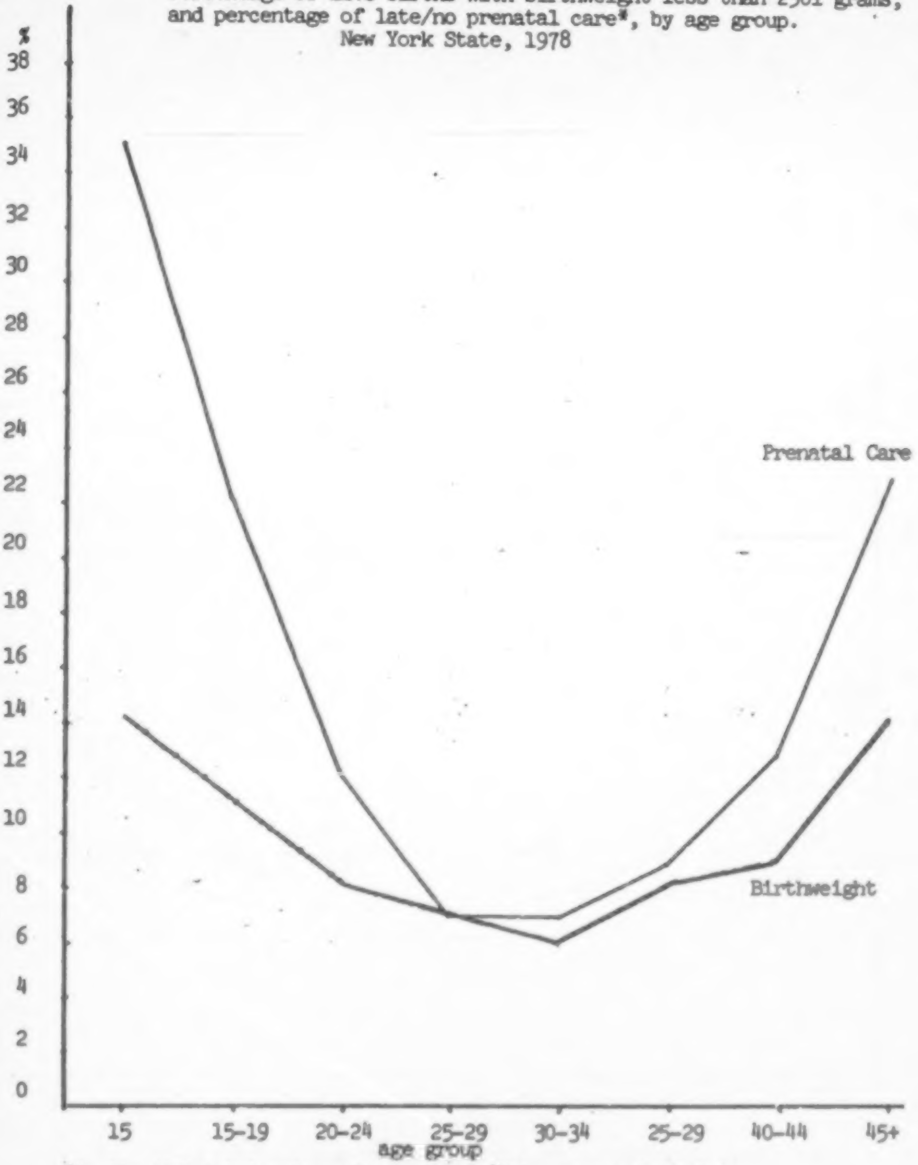
Percentage of live births with birthweight less than 2501 grams, and percentage of late/no prenatal care*, by age group.
New York State, 1978



*in the third trimester of pregnancy. Unknown not included.

Source:=Vital Statistics of New York State, 1978, Table 7.

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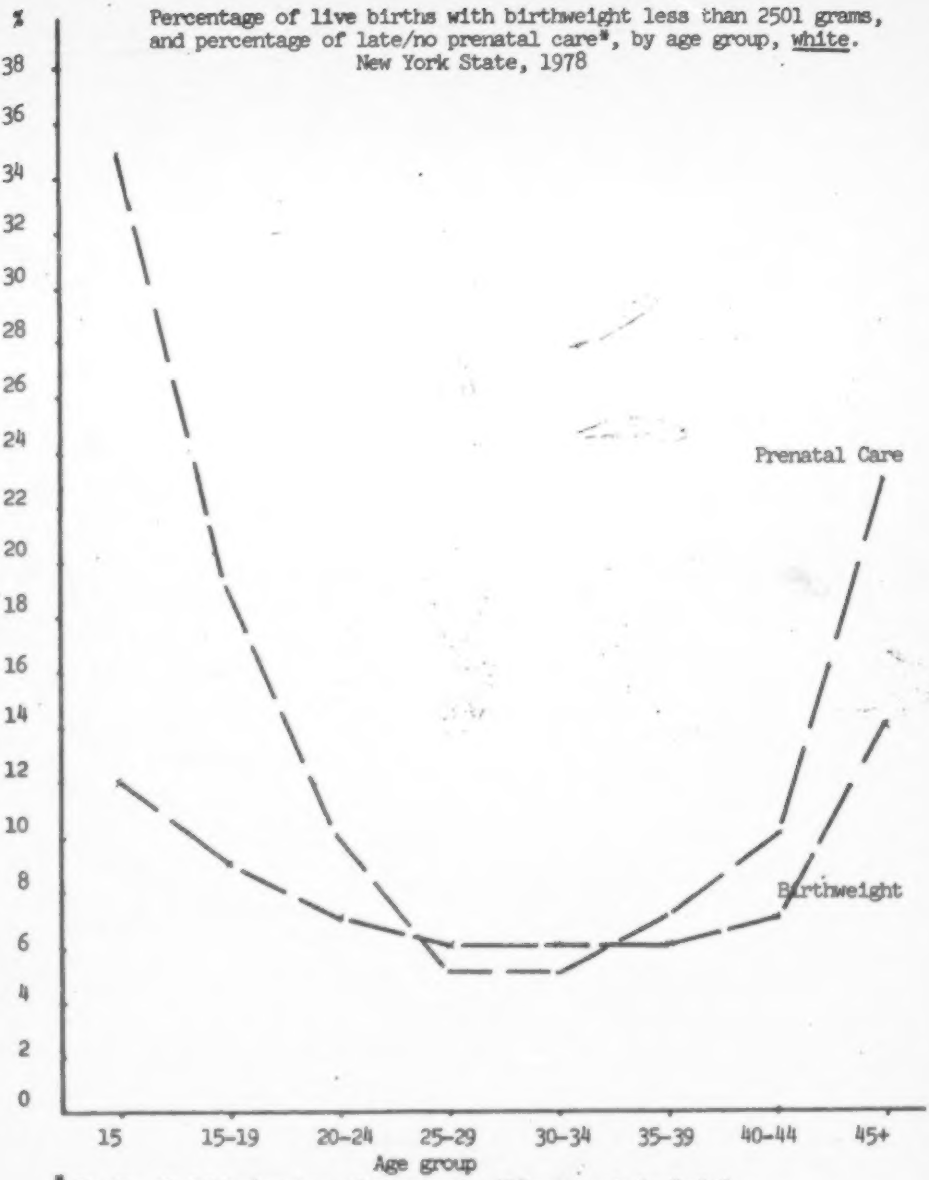
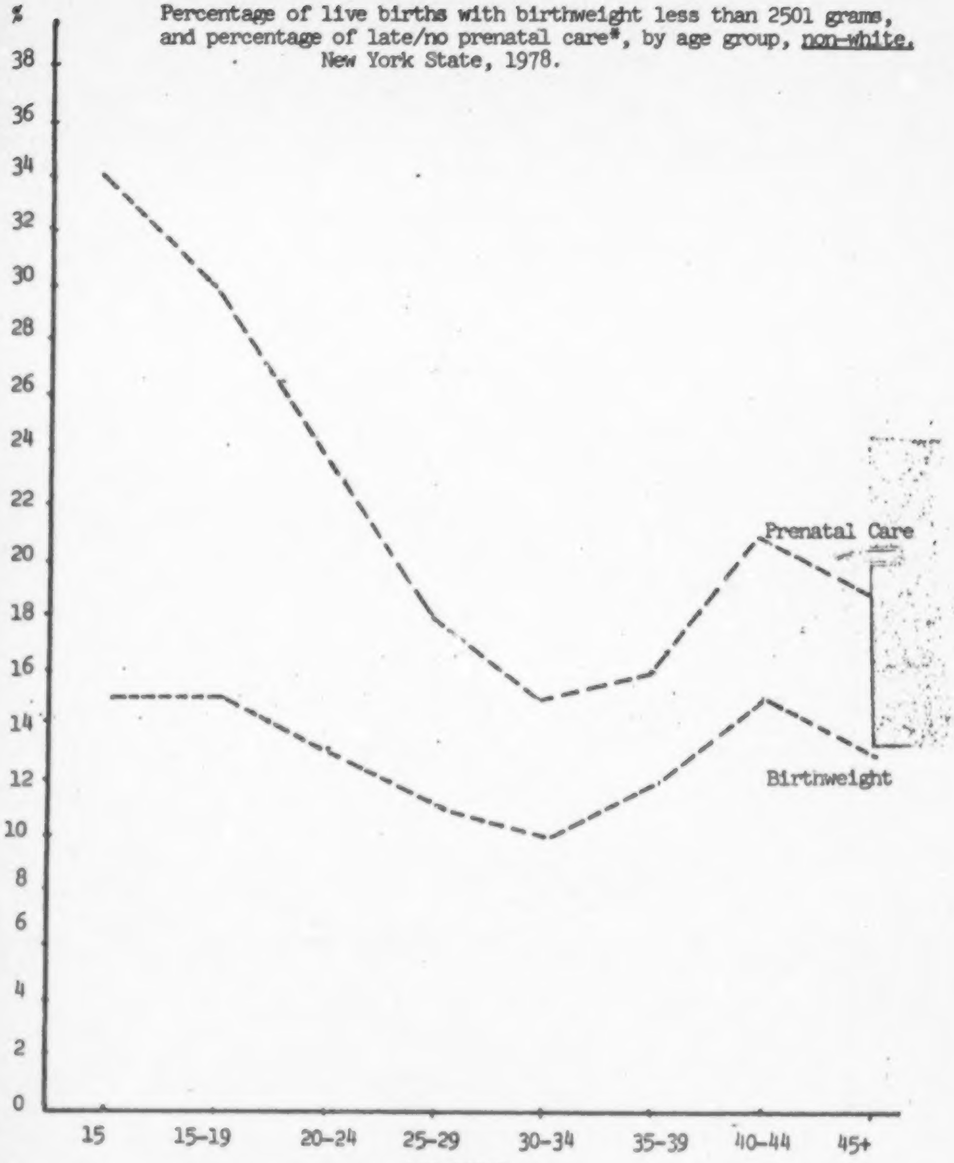


Percentage of live births with birthweight less than 2501 grams, and percentage of late/no prenatal care*, by age group, white. New York State, 1978

* In the thrid trimester of pregnancy. Unknown not included.

Source: Vital Statistics of New York State, 1978, Table 7.

BoFP 2/7/80



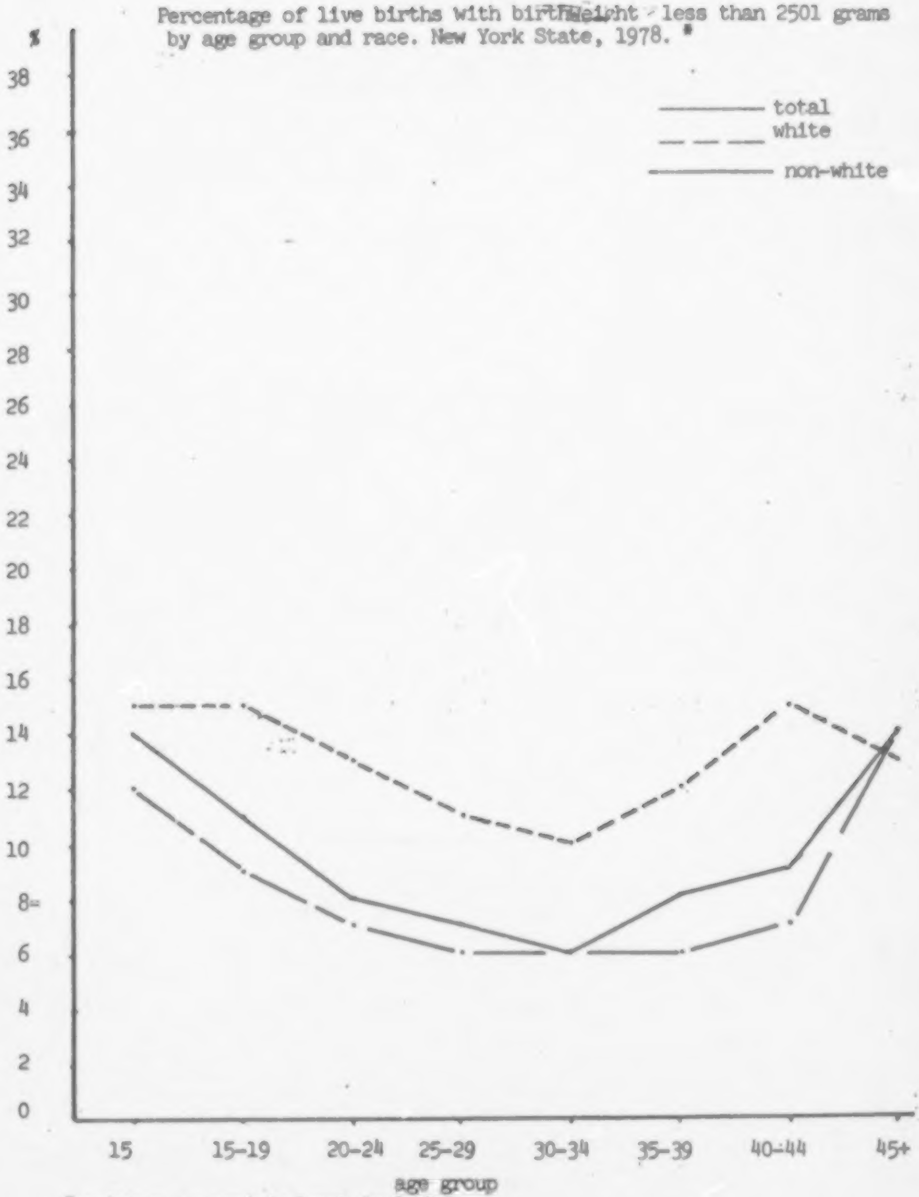
Percentage of live births with birthweight less than 2501 grams, and percentage of late/no prenatal care*, by age group, non-white, New York State, 1978.

*in the third trimester. Unknown not included.

Source: Vital Statistics of New York State, 1978, table 7.

BoFP 2/7/80

Percentage of live births with birthweight less than 2501 grams by age group and race. New York State, 1978. *



* unknown or unstated not included.

Source: Vital Statistics of New York State, 1978, Table 7

BoFP 2/7/80

STATEMENT OF MS. JUNE PERNICE, PLANNED PARENTHOOD OF CLINTON COUNTY, PLATTSBURGH, N.Y.

Clinton County is a rural county located in the northeast corner of New York State. The problems associated with adolescent pregnancy and parenthood are exacerbated in this county by poverty, low education levels, high unemployment, no public transportation, and in general, a lack of resources.

The community has long been aware of the acute needs of pregnant adolescents and adolescent parents. Agencies, physicians, and schools have over the years attempted special programs for this high risk population; none have succeeded. The problems can simply not be solved by a single group or a single service. The problems can only be solved by a community-wide effort utilizing all resources to assist not only the adolescent but her family and her partner.

Title VI is allowing this community to help its adolescents. It is not only the funding but the unique aspects of the Adolescent Health, Services, Pregnancy Prevention and Care Act which make Title VI a sound investment of federal funds.

- Commitment. Projects applying for Title VI funds had to submit proof that the proposal had community support and involvement. Title VI has served as a catalyst for agencies, schools, physicians, churches and community organizations to work and plan together.

  An example will help to illustrate how much more effective a program can be when linkages are in place. The American Red Cross sponsored prenatal classes for pregnant adolescents in 1979. Over a period of one year, only 17 adolescents attended, a small percentage of those who needed information not only on how to care for themselves but for their infants. This year because of Title VI, there is a network - the community is committed. The very first prenatal class had as many participants as were served during the entire year of 1979.

- Parental/Partner Involvement. Projects applying for Title VI had to demonstrate how the extended families and partners would be involved, and if necessary, assisted. All too often, human service projects target services only to the client, overlooking the influence of the family or partner.

  Latest studies show that teenage pregnancy is a generational problem. The family simply can not be ignored.

  In Clinton County, the Title VI program includes home visits and family conferences. Not only are program staff available for counseling but a clergy network has been established to help the parents and partners deal with some of the adjustments they must make because of the pregnancy. Working with the parents and partners appears to solidify their support of the adolescent.

- Comprehensiveness. Projects applying for Title VI funds were required to develop a plan that incorporated medical, educational, and social services. The target population, particularly in a poor county like Clinton, has a multitude of problems. Solving one is only the beginning in helping the adolescent.

  In this one small county, over 40 members make up a network of services.

- Planning. Projects applying for Title VI funds had to indicate how the program would continue with reduced, and then, no federal funding.

  Such a mandate builds accountability into the program - accountability to the community. Local funds will not be available if the program fails. The five year period of the Title VI grant provides adequate time for performance, evaluation, and planning.

The drafters of this legislation wisely included these project requirements. In a five year period, the problems of adolescent pregnancy and childbearing won't be totally solved. However, the seed dollars from

Title VI will have built a firm foundation for the community to continue and expand this program. Clinton County is only one small area. The problems are felt in every community in this nation.

Increased funding for new projects would seem to be in the interest of this new administration which is seeking opportunities to make communities address their own problems. Title VI is doing exactly that.

STATEMENT OF JBF ASSOCIATES, WASHINGTON, D.C.

This statement is submitted by JBF Associates for inclusion in the hearing record of March 17, 1981, on fiscal year 1982 funding for preventive health services programs.

JBF Associates is a national, non-profit 501 (c)(4) consultant service specializing in provision of technical assistance regarding high-risk adolescents. The primary emphasis of our organization is on sexually active youth, pregnant teens, young parents and their families. JBF Associates, which is incorporated in the District of Columbia, provides consultation on program development and implementation, policy planning and promotion, and research and evaluation. The work of our organization brings us into contact with service providers, policy-makers, researchers and private citizens interested in young people and their families and concerned about their future.

JBF Associates offers this testimony from a perspective derived from more than a decade of involvement in issues affecting high-risk adolescents. We believe our many clients who are state and local agency personnel, both public and private, give us a unique understanding of and background in the adolescent pregnancy issue.

When JBF Associates testified before Congress last year in support of the Office of Adolescent Pregnancy Programs (OAPP), we opened with an admission that critical national economic concerns at that time would likely result in a reduction of dollars for human services. Nevertheless, Congress saw fit to appropriate $10 million for OAPP and its unique

efforts to provide comprehensive services to pregnant teens and young families. That figure exceeded the Carter Administration's final budget request of $8.7 million but fell short of the $18 million initially sought by the President. And even $10 million was woefully inadequate in view of Congress' having authorized $75 million for fiscal 1981 in 1978 authorizing legislation. Surely, few programs labor under such dramatic budget shortfalls.

This lack of support for a deserving program is even more difficult to understand in light of the magnitude of the adolescent pregnancy problem in this country. It is no secret that an estimated one of every 10 young women aged 15 to 19 is becoming pregnant each year. The social and economic costs of their leaving school and joining public assistance rolls are staggering and show no sign of abating. At a time when cost-effectiveness is a keyword, the value of assisting young parents in their efforts to contribute to rather than draw from our society should be obvious.

Furthermore, OAPP has yielded dividends far beyond its funding levels. It has proven to be a remarkable incentive and catalyst in generating non-federal support for adolescent pregnancy services throughout the country. The legislation authorizing this program stipulated that funded projects would be required to link existing health, education and social services for adolescents. As a result, even though only 31 projects have been funded to date, hundreds of applications have been made. Many of those non-funded projects have taken advantage of contacts made during the application process and have secured funding from non-federal sources. The Adolescent Health Services Program, then, is facilitating the identification of local- and state-level support for pregnant adolescent services. This leverage factor should not be underestimated.

Yet for fiscal 1982 the federal pursestrings are even tighter, and this deserving program is again in jeopardy. OAPP must now justify its continued funding as a separate entity rather than as a component of a system of preventive health services block grants. And while OAPP could probably tighten its belt another notch and make do with continued meager funding, it is our firm belief that the block-grant system simply will not work in this instance. As you well know, prevention of adolescent pregnancy and the care of pregnant adolescents touches upon a multitude of sensitive issues including contraception, sex education and counseling, and alternatives to childbearing. Many states have demonstrated an unwillingness to deal with these issues in the past and would be both reluctant and unprepared to address the problem in a balanced manner.

Federal support sparks state and local involvement; it generates ideas and disseminates information. Without this stimulus, states will be forced to retrench. Communications networks among public and private organizations must be kept open for a free exchange of information, and a federal-level office meets those needs. This network further serves to reduce efforts which are duplicative at a time when resources are limited.

Another factor which militates against the block-grant approach involves the technical assistance needs of states in the program development and evaluation area. I submit that a national-level effort such as is situated in OAPP is the only viable approach to the technical assistance problem. Recognition of a need for health, education and social services for pregnant adolescents at the local or state level is merely a tentative first step. From there, substantial expertise must come into play if past mistakes are to be avoided.

It is no secret that such expertise is sorely lacking in many states. Governors and state agency heads look to the federal level for guidance--in most cases they want and need more rather than less federal involvement in their attempts to cope with the adolescent pregnancy problem. Funding through block grants with less federal "interference" would virtually guarantee the demise of many fledgling state and local efforts to deal with the problem.

Mimimum levels of technical assistance should include guidelines for needs assessment at state and local levels, recommended procedures for developing and linking services, shaping research and evaluation techniques, and suggested formats for documenting efforts on short and long-term bases. The national data collection stipulated in OAPP's authorizing legislation also requires guidance to grantees in the use of various reporting forms which will be used in that collection and in shaping appropriate evaluation schemes.

The national technical assistance effort initiated by OAPP thus far is meeting a need which could be left unmet were it to return to a state-by-state approach. Some vivid examples stand out. It is common knowledge that the southeastern portion of the country is faced with severe problems and shortcomings in services for pregnant adolescents. Yet grants awarded by OAPP have directed few dollars into this region. OAPP staff blame this on grant applications which were not of sufficient quality to merit serious consideration. As a result, technical assistance has been directed to the Southeast to prepare interested parties in the art of grantsmanship. Targeted assistance of this nature could not be expected under the block-grant approach, and a situation wherein the poor get poorer could be perpetuated.

JBF Associates would also like to take this opportunity to point out that OAPP, which is currently lodged in the Office of the Secretary at the Assistant Secretary for Health level in the Department of Health and Human Services, is not situated where it is best able to effect needed coordination with other relevant health services programs. Allow me to point out that this very small administrative entity is charged with coordinating all federal efforts in the area of adolescent pregnancy prevention and treatment. Limited funding has prevented OAPP's effectively meeting this expectation, and continued lack of support dictates that other means be found if the office is to change this.

It is our belief that, if the program remains at its present size and appropriations level, it could be more effectively incorporated into the continuum of adolescent services were it placed under the aegis of the Bureau of Community Health Services within the Health Services Administration. This would align the program more closely with Title V Maternal and Child Health Services programs and with Title X Family Planning efforts. Cooperation and coordination among related federal adolescent pregnancy efforts would be fostered, and the administrative capabilities now resting in other program areas but lacking in OAPP could be taken advantage of.

Our primary consideration should be the ability of OAPP to respond to the comprehensive health, education and social service needs of the population and to coordinate efforts relevant to this population both inside and outside HHS.

JOINT STATEMENT OF NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and Members of the Subcommittee, the National Retired Teachers Association and American Association of Retired Persons appreciate the opportunity to submit a statement concerning the Fiscal Year 1982 Labor, Health and Human Services and Education Appropriations Act.

This statement will supplement earlier oral testimony delivered by representatives of our Associations.

At the outset, we want to reaffirm that our Associations strongly support the Administration's goals to combat inflation, revitalize the economy, and balance the federal budget. However, we are deeply concerned about some proposed cutbacks to achieve these objectives. In our judgment, certain recommended sharp reductions in health and social services programs would leave gaping holes in the "social safety net" that the Administration says it has created for the truly needy. We believe that these cutbacks are ill advised and urge the Subcommittee to take appropriate corrective actions.

A. Health Planning

Our Associations strongly oppose the proposed phasing out of health planning by 1983. The Administration's fiscal 1982 budget would cut health planning by more than $89 million, from $147.1 million recommended in the Carter Administration's budget to $58 million. In addition, a $24.2 million rescission is recommended for this year.

We urge the Subcommittee to reject the rescission for fiscal 1981 and adopt the Carter Administration's budget request for fiscal 1982.

We view health planning and the certificate of need process as a viable state and local decision-making process with demonstrated successes. It remains one of the few tools that government and health care consumers have to combat rising health care costs.

Health planning is impossible to evaluate in terms of outcome measures alone. In fact, the performance of the planning process is probably best reflected in things that did not happen or occurred in a qualitatively better or more responsive manner. For example, annual expenditures for health facilities construction has continued to decline in constant dollar terms since the early 1970's, falling 26 percent from 1976 to 1979. Planning agencies have also disapproved about 20 percent of the $5 billion per year proposals that they have reviewed. The net impact is that this process has (1) successfully avoided capital expenditures where demonstrated surpluses already exist and (2) helped to reduce Medicare and Medicaid outlays otherwise expended to maintain unnecessary and costly beds, facilities, and equipment.

The cost of health planning -- less than $1 per year on a per capita basis in an industry costing more than $1,000 annually for every person in the U.S. and more than $2,500 per year for each elderly person -- is relatively small. Some experts estimate that there would be a 50 percent jump in capital construction during the next four years -- or $10 billion more under the current system -- if health planning is eliminated.

For these reasons, we reaffirm that health planning should be maintained essentially at a current services level. We believe that this is a cost effective program which clearly deserves to be continued.

B. Health Maintenance Organizations

The Administration also proposes to phase out federal support for developing Health Maintenance Organizations (HMO) by the end of 1983. This would be implemented by cutting funding in half this year -- from $55.3 million to $27.6 million -- and then reducing appropriations further in fiscal 1982, to $8.2 million.

We find this proposal to be inconsistent with the Administration's stated intent to encourage the development of alternative health care delivery systems. Moreover, there is compelling evidence that HMOs can produce significant reductions in health costs for consumers and our Nation.

We believe that continued modest levels of federal financial support are needed to make HMOs available in areas where private capital has not been invested in HMO development -- especially in areas where a significant potential for growth exists and health care costs are out of control.

Our Associations urge that federal financial assistance for HMOs should be maintained at current levels. We also recommend that the current loan program should be more carefully targeted and selective. The focus should be on areas with high growth potential as well as on HMOs serving special or otherwise unserved population groups.

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C. Home Health Services

Our Associations have a long-standing commitment to the development of home health care as a viable alternative for older Americans. Last year Congress took positive action to make home health care more readily available under Medicare by removing the three-day prior hospitalization requirement under Part A of Medicare, eliminating the 100-visit ceiling in Part A and B and removing the $60 deductible charge under Part B. We sincerely hope that the Congress will not repeal these high cost-effective benefit liberalizations.

However, Medicare and Medicaid continue to have an institutional bias. Today many older Americans are unnecessarily or prematurely institutionalized at a much higher public cost simply because alternative forms of care are not available. But if an adequate supply of homemaker/home health care, sheltered living arrangements, congregate housing and other community-based arrangements were available, an estimated 20 to 40 percent of the present nursing home populations could be maintained in less intensive and less expensive surroundings.

Our Nation's long-term goal should be the development of a complete continuum of care with a network of community-based centers. This takes on added urgency because nursing home expenditures are projected to more than double during the next five years, from $22 billion to about $45 billion in 1985. Morever, the "at risk" population -- those persons 75 years or older -- is projected to increase markedly in the years ahead.

It is essential, therefore, that our Nation develop a broad continuum of care with appropriate alternatives to institutionalization for those patients who can be maintained in their homes. One low-cost approach to test out these alternative forms of care is the home health demonstration program.

Our Associations recommend that this demonstration program be funded at $5 million. We believe that this program has a great potential to yield major benefits for a comparatively low cost.

D. ACTION's Older American Volunteer Program

NRTA and AARP urge that ACTION's Older American Volunteer Progams -- Foster Grandparents, Retired Senior Volunteer Program (RSVP), and Senior Companions -- should be funded at $94.7 million, the amount recommended in the Carter budget. This is $5.2 million above the Administration's budget request.

The Carter and Reagan budgets both recommended $28.7 million for RSVP (Retired Senior Volunteer Program) and $49.7 million for Foster Grandparents. However, the Reagan budget would cut Senior Companions by $5.2 million, from $16.3 in the Carter budget to $11.1 million.

Our Associations are pleased that the Foster Grandparent program has a notable ally -- Mrs. Reagan. She has had a long history of supporting Foster Grandparents. The program was brought to California largely at her insistence when President Reagan was then Governor of California.

Mrs. Reagan has seen firsthand the impressive results that Foster Grandparents can achieve with limited funding. Many shy and rather backward children have changed dramatically when they receive the loving care and attention of a Foster Grandparent. At present, there are almost 18,000 Foster Grandparents in 219 projects throughout the country. They generally provide valuable supportive services for disadvantaged children.

Senior Companions have helped to complement the work of Foster Grandparents by helping peer group people. Nearly 4,000 Senior Companions help homebound persons by providing homemaker/home health services, making telephone reassurance calls, checking with people on a daily basis to make certain that everything is satisfactory, and performing many other beneficial acts. The value of the Senior Companion program has been demonstrated repeatedly. We believe that the proposed modest increase in the Carter budget is warranted because Senior Companions can enable older persons to remain in their own home where they would prefer to be, instead of being forced to live in a nursing home.

Our Associations fully support RSVP which provides a very large number of volunteers at a very minimal cost. Almost 273,000 volunteers at 722 projects serve in a wide range of useful and fulfilling capacities by tutoring students, helping older persons prepare their tax returns, working as teacher aides and other ways.

Finally, we want to reaffirm that these programs should retain their separate identity and should be administered by ACTION. We would oppose efforts to incorporate ACTION's Older American Volunteer Programs in a block grant because this would almost assuredly mean substantially less funding for these efforts. In addition, these programs would lose their identity and visibility if they would be thrown into together with many other service programs. ACTION's Older American Volunteer Programs have worked extraordinarily well. And, they should continue to be administered as they are now.

E. Conclusion

Our Associations recognize that the Subcommittee has many difficult decisions to make in the months ahead, as you work to bring spending under control but still assure vital services for persons who need them. We believe that our proposals are sound substantively and from a cost effective standpoint. We urge the Subcommittee to adopt them. Our staff will be glad to work with the Subcommittee to implement these recommendations.

STATEMENT OF NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., WASHINGTON, D.C.

On behalf of the National Family Planning and Reproductive Health Association (NFPRHA), I request that the following comments be incorporated into the record of, and considered along with the testimony presented at, the hearing held by your Subcommittee on March 16 on fiscal year 1982 appropriations for the Health Services Administration of the Department of Health and Human Services. Our comments relate to funding for family planning programs under Title X of the [illegible] Service Act.

NFPRHA is a non-profit national membership organization headquartered in Washington, D.C. devoted to the improvement and expansion of the delivery of family planning and reproductive health care services throughout the United States. Our members--individual health care professionals, consumers and organizations--are committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

Title X, the "Family Planning Services and Population Research Act," is the primary pregnancy prevention program in the federal government. More than half (58%) of all federal dollars for family planning services comes from Title X. These funds help provide services to approximately 4.5 million low-income women and teenagers in every county in the nation through 5,100 individual clinic sites.

For fiscal year 1981, $166 million was appropriated for Title X, and a $4 million rescission request is pending before the Congress. NFPRHA, in seeking to be responsive to national concerns about the economy, inflation and the size of the federal budget, requests for fiscal year 1982 an appropriation for Title X family planning services of only $190 million. This figure does not provide for any growth in the program over FY1981, only for a continuation of the current level of services.

We strongly believe that Title X, the authorizing legislation for which expires on September 30, should be reauthorized this year by the Congress as a categorical grant program, with a corresponding line item provided in the DHHS budget. The details of the Administration's proposal to include federal funding and support for family planning services within a preventive health block grant to the states have not yet been revealed. However, enough is known--about block grants in general and the forthcoming Administration proposal in particular--for NFPRHA to have determined that such a proposal would be extremely detrimental to the health and well-being of those who rely upon these services.

Block grants for health and social services have not, in the past, proven efficient in providing preventive health services. Block grants allow individual states to determine whether or not to fund services that should be provided to all the nation's needy citizens, leading to situations where persons in need of services may be denied them because of their state of residence. Block grants erode national standards for provision of services, resulting in less than adequate care in certain areas of the country. Block grants reduce the federal bureaucracy by shifting administrative burdens to 50 state bureaucracies, at a high cost of inefficient duplication. Block grants do not provide for comprehensive evaluation of programs and reduce accountability for the spending of federal monies. Block grants are likely to be spent by states in ways acceptable to vocal interest groups, and not for those services designed to assist minorities and lower income groups.

Thus, the National Family Planning and Reproductive Health Association will strongly oppose any effort to place federal family planning funding into a block grant.

While arguments can be made that some federal programs have high overhead, are wasteful, do not deliver enough direct services for the funding provided, or are not suited to local needs, none of these arguments can be made about the Title X program. As the body with most direct responsibility in the Senate for allocating funds for Title X and assuring that these funds are spent appropriately, your Subcommittee must be pleased about the record of Title X family planning programs in the last few years.

Family planning is a national need that transcends state, county or local borders. The high incidences of teenage sexual activity, of unplanned births, of adolescent pregnancy, of venereal disease, of abortions across the country all require a national effort to be brought under control. Stong federal support and direction are required to assure that every person seeking family planning services--no matter in what state or locality he or she resides--receives high quality, comprehensive and competent care.

Title X has been an extremely efficient program. From 1974 to 1979, patient enrollments increased by 137 percent, while funding increased by only 34 percent. The cost per patient per year is only $90 for medical services, contraceptive supplies and counseling. This figure compares most favorably with the cost of care in the private sector where the yearly cost of oral contraceptives alone is $84, in addition to doctor's fees. There is little administrative overhead in Title X. Of the monies Congress appropriates, 95.3 percent go directly to patient services.

Title X has been a very cost-effective program. A recent study has shown that for every dollar spent for family planning by the federal government, a saving of $1.80 was achieved the very next year in health and welfare costs. Between 1969 and 1975, the federal government's investment in family planning of $584 million yielded a savings of $1.1 billion to the federal government.

Title X-funded agencies have provided a focus for the provision of all family planning services regardless of source of funding. Agencies funded by Title X have coordinated other federal programs that provide complementary reproductive health care services (Title V Maternal and Child Health, Title XIX Medicaid and Title XX social services) and have been able to assist those whose services were paid for by state or local governments, private insurers or personal fees.

Title X programs do a good job averting unintended births and concurrently lessening the number of abortions. A study conducted by the National Institute for Child Health and Human Development documented that, in a six-year period, an estimated 1.4 million unintended births were averted as a result of the Title X program.

It makes no sense--in economic, human or governmental terms--to reverse the progress made in the last decade in the area of family planning by repealing or inadequately funding the central national family planning program. The National Family Planning and Reproductive Health Association urges you to support the reauthorization of Title X as a categorical grant program with a line item appropriation for fiscal year 1982 of $190 million.

Thank you very much for your consideration of our statement and views. If we can provide you and the Subcommittee with any further information to assist you in your deliberations, please do not hesitate to contact me.

STATEMENT OF DR. GEORGE L. WALDBOTT, WARREN, MICH.

Acute fluoride intoxication usually occurs as the result of an attempt at suicide or homicide or because of mistaking fluoride compounds for such nontoxic agents as sodium bicarbonate, sugar, flour, etc.

A new source of acute poisoning has surfaced in recent years that is related to the addition of fluoride to drinking water for prevention of tooth decay. Five such incidents have been reported in the literature (Table 1) due to accidental spillage of fluoride into the water supply. Four were man-made, and the fifth was due to an inadvertent mishap.

In 1965 in Szolnok, Hungary about 80 individuals (at a restaurant and a school) became seriously ill within minutes after drinking soda water or an orangeade made with the soda water. All of those afflicted were nauseated and then vomited violently. The recovery was stated to be prompt and spontaneous. The contaminated soda water contained 300 to 900 ppm fluoride which had collected in a temporarily unused supply pipe to the bottling plant.

In 1974 in Stanly County, North Carolina, fluoridation equipment at a rural school pumped excess fluoride into the water. "All 213 individuals experienced nausea, and all 201 children (ages 6-12) and 7 of the 12 adults vomited" shortly after drinking orange juice made from an uncontaminated concentrate diluted with high fluoride tap water. Analysis of the reconstituted beverage contained 270 ppm fluoride.

On November 22, 1977, a 19-year old employee at a medical care facility in Harbor Springs, Michigan noted a metallic bitter taste in the coffee and in a cup of plain water. He vomited and felt ill for 24 hours. Three other individuals, 45-87 years of age, experienced the same illness. In one of them abdominal pain, fatigue, anorexia persisted for about a week. A falling tree had severed an electric wire that controlled the flow of the fluoride solution into the municipal water. Approximately 86 kg of hydrofluosilicic acid were released into the water system bringing the fluoride level in the discharge line up to 1000 ppm. Fortunately this mishap occurred between mealtimes when relatively little water was consumed and it was discovered and corrected within 1-1/2 minutes.

On November 17, 1978 in Los Lunas, New Mexico, equipment failure accounted for a rise of the fluoride concentration in the water to 175 ppm in one of the buildings of the elementary school. Fifteen children became ill within 30 minutes with abdominal pains, nausea, vomiting, diarrhea, muscular fibrillation and excessive salivation. It was estimated that they had swallowed between 4 and 90 mg fluoride.

The worst of the episodes warrants a more detailed description because the knowledge attained through it has furthered our understanding of fluoride intoxication. On November 11, 1979, at an Annapolis, Maryland hemodialysis facility, attendants noted some unusual behavior in 8 patients under hemodialysis. Within 1-2 hours after the treatment they became ill with nausea, vomiting, diarrhea, headaches, hypotension, dyspnea and substernal pain. One of the victims, a 36-year old male, recovered somewhat and returned home. Twelve hours later, he had to be readmitted because of cardio-respiratory arrest. He was successfully resuscitated. Another 65-year old male who had vomited blood-tinged material 1 hour and 40 minutes after the dialysis, improved sufficiently for release to his home. He died at home about 16 hours after the onset of the illness.

A technician at the water treatment plant had neglected to close a valve to stop the flow of 22% hydrofluosilicic acid into a 50 gallon fluoride feed container. According to the official report by the health authorities (1), "one thousand gallons of the acid overflowed into drains leading to sand-filter backwash and sludge-decant tanks from which decanted liquid was recycled as raw water." On November 14th, the level of fluoride in the water was 7.5 ppm (1). On November 29th a sample from a swimming pool, analysed at my request at the University of Montana at Missoula contained 15 ppm fluoride.

On November 29th and 30th, I had occasion to interview 112 residents who had become ill on the day of the spill. The interviews were carried out with the aid of a form based on data presented in my monograph "Acute Fluoride Intoxication" (2). In 10 subjects (including 2 pregnant women), the illness did not appear to be related to the accident. In 102* a multisymptomatic clinical syndrome was encountered, identical with that recorded in the literature on acute fluoride intoxication.

Of the 102 cases, 61 were females and 41 were males; their ages ranged from 11 months to 93 years. Two patients had to be hospitalized. Thirty-five appeared to be severely ill and 67 only moderately so.

Of 100 other subjects who were arbitrarily selected from the telephone book and interviewed by phone, 13 reported that they had become ill on the days of the spill, mainly with gastrointestinal disease. On this basis it is likely that in the city of 33,000 a total of 5390 cases may have been poisoned**

The following observations were made:

1. Whereas the majority of the afflicted subjects became ill between November 11th and 15th, in thirteen the disease started during the week of November 22 - 30th. These patients attributed their illness to food and beverages prepared with the high fluoride water. Indeed, the analysis of soft drinks showed levels of fluoride as high as [illegible] ppm.
2. In 25 subjects who vomited, the illness lasted only from a few hours up to 2 days. Among the others, in three the disease lingered up to day 18, the day of my interview.

* One additional case, which at first was not believed to be related to the spill was subsequently added to the series (4).

** According to the official survey by Anderson et al. (1), of 52 persons employed in the dialysis unit, 13 or 21% became ill during the week following the accident.

3. Of the 102 subjects, 18 or 17.65% had a history of allergy, 8 or 7.84% of diabetes, 6 or 5.88% of kidney stones, 5 or 4.9% were habitual alcoholics.
4. In five individuals an existing disease became aggravated shortly following the accident: In two diabetics (H.C. and D.S.), the blood sugar rose from controlled levels to 447 mg% and 600 mg% respectively. A patient with advanced heart disease (E.T.), required a pacemaker. A minor upper respiratory disease turned into acute pneumonitis (D.B.). A patient with acne rosacea (E.M.) developed severe cellulitis of the face. A sixth person, a 25-year old hydrocephalic, not included in the above survey, was reported to have had a convulsion which had never occurred previously.
5. Of four pregnant women, 2 had only minor symptoms, two others* were completely symptom-free: They consulted me because of their fear of possible damage to the fetus. In other kinds of mass poisoning, as for instance the Minamata Bay mercury poisoning in Japan (3), pregnant women seemed to be unusually tolerant to toxic agents, probably due to placental transfer of the toxic agent to the fetus. Such transfer of fluoride has been documented repeatedly.
6. In the fatal and the near-fatal hemodialysis cases, the critical stage did not arise immediately but several hours after the patient had improved temporarily.
7. In the fatal case, fluoride levels were high in lung (5.6 ppm), kidney (7 ppm), brain (0.9 ppm) and blood (4.9 ppm). Serum fluoride levels ranged from .4 to 5.5 ppm, 16 to 20 hours after the completion of the dialysis.

Whereas these 5 incidents were officially confirmed by health authorities, it is impossible to say how many additional ones have occurred which were either not reported in the literature or were not brought to the attention of the authorities. The above evidence demonstrates the danger of using the municipal water supply as a vehicle for distribution of a toxic substance.

* Excluded from survey

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FLUORIDE "SPILLS" REPORTED IN THE LITERATURE

Name of Town Reference	Date	Cause	F^- Content (ppm)	Duration of spill	Number Affected
Szolnok, Hungary Orvosi Hetilop 108:306-7, 1967	3/29 1965	Soda water plant failed to flush pipes after F^- equipment plant had been closed for repair.	<650:orangeade 900:soda water		15-20 in restaurant 55 children, 5 adults in kindergarten
Stanly, N.C. M.M.W.R., 23: 190, 1974.	3/16 1974	F^- feeder pump malfunctioned.	270:orange juice 125:water		201 students 12 adults
Harbor Springs, MI J.A.W.W.A., 72:238-43,1980	11/22 1977	Tree fell on electric wire causing failure of F^- feeder control.	1000:water	90 s	4
Los Lunas, N.M. Pediatrics, 65: 897-900, 1980	11/17 1978	Malfunction of electric relay switch.	375 (Bldg. A) 9.35(Bldg. B)		34
Annapolis, MD M.M.W.R. 29: 134-36, 1980	11/13 1979	Worker neglected to close valve.	36:city water 50:water of dialysis unit	17½ hrs.	<6000 (?)

Fluoridation: A Clinician's Experience

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ABSTRACT: In 1954 I described a case of chronic fluoride poisoning from artificially fluoridated water, in which the patient exhibited a multisymptomatic clinical picture without noticeable skeletal changes. Subsequently, others and I have confirmed this "nonskeletal phase" of the disease from fluoride in water and in air (in workers in fluoride-emitting factories and in people residing near such factories) and from fluoride-containing drugs. Further details on this disease are presented. In view of the constantly expanding use of fluoride in industry as well as its increase in food, water, and other hidden sources and because of the reactivity of the fluoride ion, the implications of these findings with respect to the etiology of several heretofore unexplained illnesses are discussed.

MOST PATIENTS with chronic intoxication from a poisonous substance exhibit a variety of subtle symptoms before features typical of the respective poisoning become manifest. In chronic lead poisoning, children complain usually of general malaise, headaches, gastrointestinal upsets, and similar vague manifestations for years before the appearance of more tangible evidence, such as the lead line of the gums and the radial palsy.[1] Similarly, in long-term exposure to carbon monoxide, intermittent episodes of vertigo, chest pain, and headache are common long before evidence of damage to the brain and heart develop.[1] Since these subtle manifestations are common to many other diseases, early diagnosis of any low-grade poisoning is usually most difficult.

It is therefore not surprising that the effects of long-term intake of fluoride other than its characteristic features in bones (osteosclerosis) and teeth (mottling) have not been brought to the attention of the medical profession, despite prolonged and extensive use of fluoride both for prophylaxis against tooth decay and in the treatment of osteoporosis. Indeed, a wide spectrum of subtle, slowly developing symptoms were described in the classic monograph by Roholm[2] 40 years ago in conjunction with skeletal changes in cryolite workers exposed to large amounts of airborne and ingested fluoride. It has since been elaborated upon by other investigators in fluoride-exposed industrial workers,[3-5] in persons residing near fluoride-emitting factories,[6-12] in areas where water naturally contains high levels of fluoride,[13] in persons drinking artificially fluoridated water,[14-21] and recently in a case of subacute intoxication caused by habitual inhalation of an organofluoride anesthetic.[22]

On Feb 8-10, 1978, the Ad Hoc Committee, Strategy Workshop for Osteoporosis Research, studying short-term the use of fluoride ion in doses ten to 100 times those considered effective for prevention of dental caries, advised against the use of this method of treatment because the "potential for long-term toxic effects has not been evaluated." They explained that "unanticipated late manifestations of toxicity" may become evident after many years. Others[23] have pointed to the development of gastrointestinal hemorrhage in infants and young children after the use of minute, presumably safe doses (0.5 mg) of sodium fluoride for prevention of tooth decay.

An editorial published in June 1978 by the American Dental Association[24] also suggested the possibility of adverse effects from the formerly accepted practice of supplementing fluoride in infants and young children and recommended "lowered extra dietary fluoride doses." The administration of sodium fluoride tablets in milligram doses to pregnant women is no longer legal according to the Food and Drug Administration.[25]

I became aware of adverse effects of fluoridated water in 1954 and have since encountered several hundred cases of low-grade nonskeletal toxicity due to the minute amounts present in artificially fluoridated water (1 mg/1,000 ml). The following case material presents some of the data obtained concerning this disease, with particular reference to its diagnosis.

CASE REPORTS

Case 1. In 1954, a 40-year-old female resident of Bay City, Michigan, was referred to me by her family physician for allergic studies because of painful spastic bowels, frequent nausea and vomiting, bloating of the abdomen, polydipsia and polyuria, and persistent migraine-like headaches of about three years' duration. A diagnostic survey, however, failed to show that allergy was involved. Whenever she was away from the city, her mouth and throat no longer felt dry and she was no longer thirsty, nor did she experience the cramps in the abdomen and the headaches. Neither she nor I realized at that time that Bay City's water had been fluoridated since 1951.

Case 2. In the fall of 1954 the case of a 35-year-old woman of Highland Park, Michigan, provided more tangible evidence of

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poisoning from fluoridated water.[14] Very noticeable white and brownish stains on her teeth had been diagnosed by her dentist as dental fluorosis. She was constantly nauseated, vomited frequently, had periodic, sharp epigastric pain and diarrhea, and complained of pain in the lower back. Her general health had gradually deteriorated until she was bedridden. Although her physician had suggested that the current illness might be related to drinking water, Highland Park's water, fluoridated since 1952, could not have been responsible for the dental condition because mottling occurs only during the tooth-forming years, up to age 12.

She reported progressive weight loss, had repeated hematúria, uterine hemorrhages, and constant pain throughout her head. Her eyesight had gradually deteriorated. She had noticed scotomas in both eyes and lesions on the arms and legs, resembling somewhat subcutaneous traumatic suffusions. Weakness in the hands and arms prevented grasping certain objects. Furthermore, due to loss of control of her legs and lack of coordination of her thoughts she eventually became incoherent, drowsy, and forgetful and was obliged to give up her housework.

In her childhood she had lived in a natural fluoride area in China where dental fluorosis was common. Roentgenograms of arms, legs, and pelvis, however, showed no evidence of skeletal fluorosis, which is characterized by thickening of bone substance, calcification of ligaments and tendons, and arthritis of the spine.

The patient was hospitalized for diagnostic studies. Consultations by a neurologist, an orthopedist, an ophthalmologist, a hematologist, a cardiologist, an endocrinologist, and a gynecologist were unrevealing. They considered the illness serious but were at a loss to establish an overall diagnosis. One consultant suggested the disease might possibly be of psychosomatic origin. The examination was essentially negative, except for tenderness in the lumbar spine, exaggerated patellar reflexes, and decreased muscle power in both hands. The only remarkable laboratory finding was a blood calcium level of 11.6 mg/dl. The 24-hour urine specimen contained 1.38 mg of fluoride and another, 1.37 mg.*

Until completion of the preliminary tests in the hospital, the patient had used fluoridated Highland Park water that she had brought with her to the hospital in plastic bottles. After the tests were completed, she began drinking unfluoridated (0.1 ppm) Detroit water. Within two days the gastrointestinal symptoms and headaches subsided without medication, and she was soon well enough to be discharged.

At home she strictly avoided fluoridated water for drinking as well as for cooking her food and avoided both tea and seafood because of their high fluoride content. The headaches, eye disturbances, and muscular weakness disappeared in a most dramatic manner. After about two weeks her mind began to clear, and she had a complete change in personality. For the first time in two years she was able to undertake her household duties without having to stop and rest. Within a four-week period she had gained five pounds. During the following two years, numerous studies were done with the patient's consent.

On Oct 11, 1955, she was given an intradermal injection of sodium fluoride 0.1 ml of a 1:1,000 solution or 0.1 mg, which produced an erythema about 5 cm in diameter. Within 30 minutes of the injection a red streak developed along the arm from the site of the injection leading toward the axillary lymph glands. The patient had paresthesias in the hands and fingers and a frontal headache which reached its climax after about four hours and lasted for 48 hours. This was accompanied by general malaise; there were no other symptoms. A few days later she was given a similar test with saline solution with no effect whatsoever.

To determine urinary fluoride excretion, on Aug 15, 1956 she was given 15 mg of sodium fluoride in 300 ml of water on an empty stomach. She was not aware that the water contained fluoride. Within ten minutes her face became flushed and she developed an excruciating headache associated with marked nausea, sensation of flashing lights in both eyes, and severe pain in the arms and legs. This was followed shortly by diarrhea and cramping pain in the lower abdomen. Throughout the day the patient was semicomatose and for three more days felt "dazed." She noticed multiple suffusion-like lesions on her body and a swelling of salivary and parotid glands, features which had been present two years previously during her illness.

The episode was so severe that all further testing had to be abandoned. The patient recovered completely without treatment other than avoiding Highland Park's fluoridated water. The ease with which this disease could be reproduced repeatedly by administering minute amounts of fluoride was striking.

Comment. In November 1954, at the request of Dr. W. P. Martzowka in Saginaw, Michigan, I reviewed the case histories of 30 people with an unusual disease. He had become suspicious of fluoridated water because their illness gradually cleared completely after termination of fluoridation in Saginaw. Nine of the 30 people described a disease identical to that of the Highland Park case. Some had had relief when they were away from Saginaw for even short periods. Most of them had not been aware they had been drinking fluoridated water until they were confronted with voting on fluoridation. Some of the 21 individuals whose illness I had not related to fluoride at that time suffered exclusively from bladder and bowel symptoms which, as I later learned, are also a part of the clinical picture of chronic fluoride poisoning. Another patient, a 12-year-old boy, had epileptiform convulsions, probably caused by calcium deprivation, a major feature of acute fluoride intoxication.[16]

Case 3. One of the Saginaw patients, a 42-year-old salesman, was about to give up his job because of progressive pain and numbness in his hands which prevented grasping the steering wheel of his car. This condition became so severe that he often had to stop on the highway. Finally he became suspicious of Saginaw's water because the disease invariably improved when he was on extended sales trips away from Saginaw. When fluoridation was abandoned there, he quickly recovered.

Comment. In contrast to the Saginaw cases, in which the illness was recognized after cessation of fluoridation, in Windsor, Ontario, ill effects were detected after fluoride was introduced into the water supply on Sept 11, 1962. The local health department did not announce in advance when fluoridation would begin. This afforded an excellent opportunity, more reliable than a double-blind test, to determine whether fluoridated water was the culprit. Two weeks after its initiation, when the press announced the event to the public, eight individuals had diagnosed their own disease.

Cases 4, 5. Two of the eight, a 57-year-old nurse and a 38-year-old woman, who had been in the habit of drinking one or two glasses of water before breakfast, suddenly had abdominal cramps and vomiting immediately after their customary morning drink. During the course of the day, they developed headaches, pain in the lower spine, and numbness and pains in the arms and legs. Never before had they had any such discomfort. They were not then aware that Windsor's water was being fluoridated. The nurse's physician first provisionally considered a stomach ailment, but his medication was of no avail. After several days of careful observation, he suspected the water might somehow be involved and advised her to discontinue drinking it but asked her not to disclose his diagnosis to anyone lest it jeopardize his position in the eyes of some of his colleagues. The other patient resorted to the use of distilled water on her own. Both recovered promptly upon eliminating fluoridated water.

Case 6. A 13-year-old schoolgirl had increasingly severe migraine-like headaches starting in mid-September 1962. Simultaneously, pain and numbness in the arms and legs and a distinct deterioration in her mental alertness interfered with her attendance at school. A consulting neurologist ruled out a brain tumor, and intradermal skin tests to determine whether the headaches were of allergic origin were negative. On the advice of an individual who had been similarly affected, the child stopped drinking Windsor water. Her illness began to subside and after ten days her health was completely restored. On Mondays and Thursdays, however, the headaches recurred when, inadvertently, after gym classes, she quenched her thirst with Windsor tap water. These recurrences ceased upon confining her drinking at school to her own distilled water. Subsequently, a double-blind test under the guidance of the Windsor physician confirmed the relationship of the disease to fluoridated water.

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*The urine was collected in a glass jar. These values, therefore, were probably too low since fluoride tends to combine with silicates in glass.

Comment. The Windsor and Saginaw cases also proved beyond doubt that no chemical other than fluoride caused the disease, because the illness occurred after the addition and subsided promptly after the removal of fluoride from the drinking water, without the patients' knowledge. Numerous similar cases have since come to my attention from many fluoridated areas of the United States. In Milwaukee, in April 1969, I interviewed several patients who developed the disease shortly after moving into the city.[20]

Case 7. The climax of my experience was the case of a 45-year-old male Milwaukee resident, examined on April 2, 1976, who moved to three different localities during a three-year period.[28] His illness promptly cleared each time he moved away from the fluoridated water supply of Milwaukee and recurred upon his return. He had had no knowledge of fluoridation nor of the fact that in the three towns in which he regained his health his drinking water was not fluoridated (0.1 - 0.15 ppm).

Comment. Other physicians have brought similar cases to my attention. The following account of a patient studied by Dr. C. D. Marsh of Memphis, Tennessee, is a typical exampie.

Case 8. A 62-year-old woman residing in Memphis (not fluoridated at that time), invariably developed the above-described symptoms on trips to Washington, DC, and Richmond, Virginia, during 1952 to 1956, and always improved promptly within a few days after her return home.[18] This experience drew her attention to drinking water as a possible source of her trouble, though she had no knowledge of fluoride or fluoridation. When she learned that both Washington and Richmond added fluoride to the water supply, she averted recurrences on future trips to the two cities by taking several bottles of Memphis water with her and avoiding fluid foods.

She subsequently had sudden new episodes of this illness, this time to her surprise while she was at home. Dr. Marsh was able to trace these recurrences to a tranquilizer (trifluoperazine) prescribed by him and, on another occasion, to a new toothpaste. Neither she nor her physician had been aware that both the drug and the toothpaste contained fluoride.

After the patient had regained her health, I gave her, with her consent, an intradermal injection of 1 mg of fluoride. She was not aware of the nature of the test. Within half an hour she developed excruciating pain in the abdomen, headache, backache, and profuse nasal discharge, followed by diarrhea and lethargy—the same group of symptoms from which she had suffered on previous occasions from fluoridated water, toothpaste, and the fluoride-containing tranquilizer. Subsequently, a double-blind test carried out by Dr. Marsh further confirmed fluoride as the cause of the disease.

DISCUSSION

Diagnosis

The events in these cases leave no doubt that the illness was caused by fluoridated water. The prompt recovery when no longer consuming the water, the recurrence on its resumption, and recurrences after fluoride intake from sources other than water (all without the patients' knowledge that they were being exposed to or consuming the halogen) and their failure to respond to other therapeutic measures clearly established the diagnosis.

TABLE 1. Number of Cases of Neighborhood Fluorosis Studied

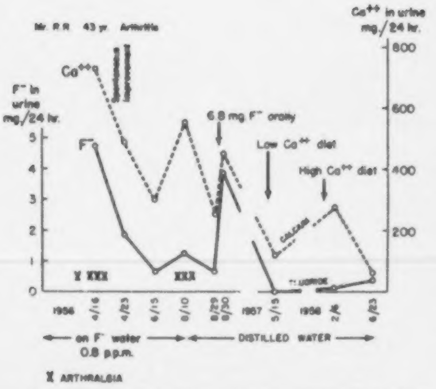
	No. of Cases	*Source*
Dunnville, Ontario (1968)	28	Fertilizer factory
Wabash, Indiana (1969)	6	Secondary aluminum smelter
Kitimat, BC (1971)	22	Aluminum smelter
Bolzano, Italy (1971)	24	Aluminum and magnesium smelter
Clarington, Ohio (1972)	36	Aluminum smelter
Buckeystown, Md (1976)	5	Aluminum smelter
Urbana, Ohio (1978)	58	Enamel smelter
Total	179	

In many instances, additional double-blind studies were done. After strict elimination of fluoridated water, the patients received three identical bottles of water labeled No. 1, 2 or 3. Two bottles contained distilled water, while the third contained 1 ppm fluoride as sodium fluoride. The patients consumed the water of bottle No. 1 for one week, bottle No. 2 the second, and bottle No. 3 the third. Neither the patient nor the physician was aware which bottle contained fluoride. Other tests consisted of injections of NaF at various concentrations.

The manifestations encountered in the above cases are identical to those observed in individuals working in or residing near fluoride-emitting factories, except for the additional respiratory involvement in intoxication from airborne fluoride. I have studied nearly 200 cases here and abroad (Table 1), some of which have been described elsewhere.[9] In 1978 Waldbott and Lee[5] reported a detailed account of a patient who was exposed intermittently for ten years to HF fumes in an oil refinery and who exhibited the identical clinical picture. The first detailed report in the US literature was that of a 27-year-old nurse, habitually sniffing a fluoride-containing anesthetic, who manifested the same symptoms before the development of skeletal changes.[22]

Laboratory Criteria

In an attempt to establish laboratory criteria for this disease, I have studied urinary fluoride excretion in more than 300 patients and carried out other biochemical determinations. In my experience, urinary fluoride measurement is not reliable in determining exposure to or ingestion of fluoride unless the values are markedly elevated, which is unlikely when fluoridated water is consumed at 1 ppm (about 1.0 to 1.5 mg of fluoride a day). Urinary fluoride certainly provides no clue concerning an ill effect from the halogen, since some patients with severe symptoms eliminated in their urine less than 1.5 mg of fluoride, whereas others



Urinary F^- and Ca^{++} excretion in 43-year-old man with chronic arthritis (0.8 ppm in drinking water) on low and high calcium diets. Notice positive correlation of urinary fluoride with calcium levels. High urinary fluoride excretion at outset of study was caused by excessive consumption of tea.

with higher values showed no ill effect. We must also consider that young children have a greater tendency toward fluoride retention than adults. Their low urinary fluoride values, therefore, can be misleading with regard to evaluating fluoride intake and its effects on health. Moreover, after cessation of excessive fluoride intake, larger amounts than are being taken into the system are being excreted in the urine due to sequestration of stored fluoride.[27]

Some correlation of urinary fluoride and calcium excretion was noted occasionally, as in a 43-year-old man who was a heavy tea drinker* (Figure), but this finding was by no means consistent. Similarly, increased levels of alkaline phosphatase, lactic dehydrogenase, and serum uric acid were noted but were not sufficiently consistent to be significant. In September 1978 I observed a 29-year-old woman with low serum copper values (87μg/dl) (normal, 90 to 150) and high urinary copper values (75 mg/24 hr) (normal, 0 to 38) which became normal as the patient's symptoms of poisoning (mainly paresthesias, myopathy, headaches, arthralgia, and episodes of gastroenteritis) subsided after switching to distilled water. A disturbance in copper metabolism has been reported by Allcroft and Burns[28] in fluorosis of cattle. I have also noted minor electroencephalographic and retinographic changes coincidentally with the neurologic features, which likewise cleared as soon as the patients recovered.

Critique

During the 1950s and early 1960s, numerous authors took issue with the diagnosis of nonskeletal fluorosis in some of the cases described herein. It has been stated that no other physicians have reported nonskeletal and nondental changes in fluorosis.[29] Actually many of my patients were referred to me to confirm another physician's diagnosis of fluoride poisoning.[30] Objections have been raised concerning the technic of the double-blind tests because in some of my studies the concentration—not the dose—of fluoride was higher than 1 ppm.[30] Throughout the years I have made numerous modifications of this test, always with the same results. Some have said the diagnosis has not been "documented,"[31-33] referring possibly to the absence of fluoride determinations in the blood. Serum fluoride assays are desirable, especially in acute intoxication, but because the halogen is promptly removed from the bloodstream, they do not represent an obligatory criterion of fluoride exposure, and certainly not of adverse effects due to fluoride.

Fluoride determinations of the iliac crest, performed at my request on several individuals, were in the range of 450 to 550 ppm, values which some consider "normal" and others consider slightly elevated.[33]

Wide Spectrum of Symptoms

The multiplicity of symptoms, their vagueness in the initial stage of the disease, and the fact that they are common to many other diseases have been another reason for questioning the diagnosis.[34] Fluoride is one of the most active of the electrolytes and it readily penetrates the membranes of every cell in the body. It is present at high levels in soft tissue,[35] not exclusively in teeth and bones as formerly believed.[36] We must therefore anticipate that in chronic fluoride intoxication numerous organs are involved in view of its known action on many enzymes and its strong affinity for calcium.

It has recently been reported that in an acid body fluid (gastric juice, urine) fluoride tends to form the irritating hydrofluoric acid,[37] which provides a reasonable explanation for the development of gastritis in hyperacidic patients and for urinary tract disease. In 60 retired workers of a fluoride-emitting aluminum smelter, Czerwinski and Lankosz[4] encountered an incidence of gastritis in 50% and of gastric duodenal ulcers in 12%.** In a 9-year-old boy, who was twice subjected to gastric surgery, doses of fluoride equivalent to those consumed in water fluoridated at 1 ppm induced gastric hemorrhage before physicians recognized that the damage was caused by fluoride tablets.[38] Some infants have had gastrointestinal bleeding caused by daily ingestion of vitamins containing 0.5 mg of fluoride.[39] In a recent survey in an Ohio town, colitis occurred in 21.7% and acute abdominal episodes suggestive of bowel obstruction in 17.8% of 109 cases exposed to fumes from an enamel smelter.[15]

Joint involvement, one of the most common features of skeletal fluorosis, is frequently encountered in the preskeletal stage already described. Pinet and Pinet[37] have shown that the radiologic findings of endemic skeletal fluorosis (148 cases) in the Sahara are identical to those attributed elsewhere in elderly persons to "aging." With advancing age, fluoride levels in the body increase, as does also the incidence of arthritis.

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*Tea leaves contain up to 200 ppm fluoride.

**Gastric ulcer was also encountered in skeletal fluorosis due to habitual inhalation of a fluoride-containing anesthetic.[40]

Damage to arteries is suggested by the finding of high fluoride levels (up to 8,400 ppm) in two individuals less than 20 years old from Grand Rapids (fluoridated since 1945) and 2,340 ppm in another individual in a nonfluoridated city.[38] In the aorta fluoride deposition does not correlate with that of calcium,[39] and thus its effects are not likely to be neutralized by combining with calcium. In one premature infant with calcification of arteries throughout his body, the aorta contained 59 ppm fluoride.[10] Pericapillary toxic inflammation was found on histologic examination of Chizzola maculae,[11,43,44] a feature (described later) occurring early in the disease, which might conceivably represent the initial stage of a calcifying process.

Kaul and Susheela[40] elaborated on the explanation of the neuromuscular involvement. Polydipsia and polyuria have been documented repeatedly in fluorosis,[18] as well as experimentally.[41,42] The evidence I have presented furnishes a reasonable explanation for the multiplicity of the manifestations.

In reviewing the wide spectrum of symptoms, it should be noted that often only a few symptoms are present, rather than the complete clinical picture described. For instance, a 17-year-old white boy had excruciating chest pain (fibromyositis?) for three years associated with polydipsia and polyuria (up to 3,530 ml/day, containing 3.2 mg of fluoride) and frequent headaches. After other possible explanations for the disease were ruled out he eliminated fluoridated water, whereupon the pain subsided completely. On one occasion when the patient inadvertently neglected to follow strictly his distilled water regimen the pain recurred for two days. Arthritis dominated the clinical picture in the patient in the Figure, lower urinary tract disease or colitis was predominant in others.

In several publications,[11,43,44] attention has been drawn to the suffusion-like, round or oval, pinkish-brown lesions on the extremities and trunk, mainly in women and children, designated Chizzola maculae, which must be considered an early and important diagnostic sign of the disease. These lesions clear after five to seven days without changing color, in contrast to traumatic suffusions. They are usually asymptomatic but do occur in conjunction with mottled teeth in children, especially during the summer months.

Implications of Findings

The omnipresence of fluoride in the environment, its strong reactivity, and its presence in numerous organs of the body are likely to have far reaching implications. They might furnish a clue to the etiology of certain illnesses of unknown causes. Fluoride enters our body from food, water, and air, and from many other hidden sources in our environment (Table 2).

During recent decades the great expansion of the use of fluoride, especially in the smelting, glass, enamel, oil, and numerous other industries, has paralleled its increase in our daily diet, in our water supplies, and in the air we breathe. Would it not be desirable, therefore, to explore to what extent this highly reactive ion present in everybody's bloodstream contributes in a given population to the etiology of certain kinds of arthritis, gastritis, colitis, lower urinary tract disease, chronic headache, and other neurologic symptoms which in the past have defied a satisfactory explanation?

TABLE 2. Examples of Hidden Sources of Fluoride [illegible]

	ppm
Air near welding operations in fertilizer factories	0.6 - 137* 0.6 - 10.2**
Asbestos	70 - 579
Bottled water	0.8 - 12.2
Coal	14 - 1440
Detergents	0.4 - 63.4
Dust near aluminum smelter fiberglass factory	5420 - 6200 40.4
Fertilizer	0.003 - 41.1
Pollen	2.4 - 3.62
Tobacco	17 - 26.8
Wood dust	1.1 - 12.6

*0.5 - 112 mg/cu m.
**0.5 - 8.5 mg/cu m.

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STATEMENT OF SUZANNE ROSENTHAL, EXECUTIVE VICE PRESIDENT, NATIONAL FOUNDATION FOR ILEITIS & COLITIS

The National Foundation for Ileitis and Colitis (NFIC) has appreciated the interest, concerns and courtesy shown by members of the Senate Appropriations Sub-Committee on Health and Human Services, when it has appeared before it to provide testimony on appropriations for the National Institutes of Health budget and especially for the budgetary needs of the National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases, (NIADDKD).

Ileitis and ulcerative colitis are serious, chronic digestive disorders of the small and large intestines, know collectively as inflammatory bowel disease (IBD). Between one and two million Americans -- at least 200,000 of them children under 16 -- suffer from these diseases, which strike regardless of age, race or socioeconomic status. The incidence of IBD is rising steadily, yet the cause and cure remain unknown.

The costs of IBD to this country are staggering, both in terms of dollars and lost productivity. According to the Report to the Congress of the National Commission on Digesitve Diseases in 1979, the annual cost of Crohn's disease and ulceravie colitis approaches $645 million, ranking only behind the cost of lymphatic cancer, cirrhosis of the liver, and gall bladder disease.

The economic burden of these diseases falls most heavily on middle-aged persons at the peak of their potential productivity. The result is an impaired efficiency of the work force and the expenditure of large sums for social welfare and health insurance. Because inflammatory bowel disease is chronic, and permits long survivial with extensive disability, the financial drain on patients and their families is catastrophic.

The Foundation in its 1981 fiscal year has committed almost 80% of its expense budget to fund vital research and education programs. Indeed, during its brief existence, it has allocated almost $4 million dollars to fund basic and clinical research studies which are leading to a greater understanding of the disease mechanism to uncover the cause and cure of these dibilitating and life threatening diseases.

The research and education efforts by the Foundation vividly illustrate the unique linkage that can exist between the private and government sectors. We recognize that government cannot do everything and indeed it should not. Private groups, such as the Foundation, can and are doing many tasks with greater efficiency and cost effectiveness, than government. Our efforts are abetted by our more than 15,000 members; volunteers who provide that essential person-to-person, human sensitive touch. The Foundation, a relatively new organization, yet in its brief period of existence it has demonstrated our commitment to help those afflicted with ileitis and colitis, and to work with other organizations concerned with all digestive diseases.

We will do our share. However, to help those who suffer from inflammatory bowel disease (IBD), we must also rely upon our partner in this war upon disease -- government.

The Foundation is particularly concerned with the proposed Training Budget cuts. We ask that you remember young investigators are the hope of the future -- without them we face scientific stagnation. We urge this committee's careful consideration to insure continued funding for training physicians and other health professionals.

In addition, although we have not had access to the specific breakdown by program dollars, we are basically in agreement with the funding level of $380,594,000 for the National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases, (NIADDKD) as recommended in the President's budget for the 1982 fiscal year.

The Foundation is a founding member of the Coalition of Digestive Disease Organizations. We urge consideration for support and funding of the recommendations of the Commission on Digestive Diesease, especially as it concerns appropriate levels of funding to insure the continuing operation of the National Digestive Disease Advisory Board, and the National Digestive Disease Clearing House.

The Foundation also shares the deep concern expressed by the Coalition on indicated reductions of research support in digestive disease research.

The National Foundation for Ileitis and Colitis is a voluntary non-profit organization devoted to research into the cause and ultimate cure of ileitis and colitis, and to the education of patients, physicians and the public. Since its inception in 1967, the Foundation has grown to 33 chapters nationwide. Its more than 15,000 members are a committed group of lay volunteers and distinguished physicians, including internists, gastroenterologists, family practitioners, pediatricians and surgeons. This unique partnership of lay and medical leadership has proved essential in furthering the goals of the Foundation.

NFIC is incorporated under the non-profit laws of the State of New York, and is exempt from federal income taxes under Section 501 (C) (3) of the Internal Revenue Code. It is a member in good standing of the National Health Council, and a founding member of the Coalition of Digestive Disease Organizations. NFIC files regular reports with the Philanthropic Advisory Service of the Council of Better Business Bureaus, the National Information Bureau, and the New York State Department of Charitable Solicitations Bureau.

STATEMENT OF DR. SAMUEL S. HERMAN, ASSOCIATE VICE PRESIDENT FOR RESEARCH, TEMPLE UNIVERSITY

Thank you for this opportunity to present to the Committee a statement regarding the role of the Division of Research Resources in developing a wide institutional base of support for biomedical research in the United States.

I am Dr. Samuel S. Herman, Associate Vice President for Research at Temple University, where I am the principal advisor on biomedical research policy and research program development. I am also responsible for oversight of sponsored research at the Health Sciences Campus which is comprised of a medical school, dental school, pharmacy school, college of allied health professions, and a university teaching hospital. In recent years I have also been Vice President and President of Federated Medical Resources, Inc., which is located in Honey Brook, Pennsylvania. This is a nonprofit organization that operates a model 156-acre facility dedicated to meeting laboratory animal needs of its incorporating members, the five medical schools of Philadelphia. Moreover, my 12 years' experience, prior to work at Temple, as a scientist-administrator at the National Institutes of Health has equipped me to understand both sides of the Federal Government/university relationship.

In these various positions I have had an opportunity to familiarize myself with all components of the Division, including most recently the Minority High School Summer Research Apprentice Program. For example, in addition to membership on the scientific advisory committee for Temple's Adult General Clinical Research Center, I have chaired since 1972 the medical school's research committee which advises on uses of the Biomedical Research Support Grant (BRSG). Also, in 1979 I planned and organized, in close cooperation with Division staff, a pilot conference of BRSG Principal Investigators in the greater Philadelphia area.

Overall Role of Division of Research Resources

Through programs of this Division, NIH has provided since 1962 a unified approach toward developing and ensuring the availability of resources to meet research needs that are primarily institutional in character. The Division's grants, for example, have helped research institutions meet their needs for improved animal facilties; for specialized computer centers; for locally administered, flexible research funds; and, for general clinical research centers where studies can be conducted over a broad range of human diseases. By means of these grants, the Division has contributed materially to stabilizing and strengthening institutional biomedical research efforts. The Division's programs complement and buffer to some extent the polarizing and fragmenting effect on institutions of dealing solely with a variety of categorical approaches and demands. These activities, it may be said, symbolize a belief that the health of the Nation's biomedical research enterprise is dependent on institutional integrity and stability -- that grantee institutions must not be treated as merely convenient sites for the conduct of research without regard to their continued viability. In addition to helping serve the research needs of the whole institution, these programs have greatly enlarged the productivity and efficiency of research supported by the categorical NIH Institutes.

As the Committee considers FY 1982 appropriations for the National Institutes of Health, I urge it to keep in mind the fact that NIH supports in excess of 40 percent of the Nation's biomedical research and development. The very magnitude of that support has engendered an interdependency. NIH is as dependent on academic research institutions for the conduct of research as the institutions are dependent on NIH for support. Resource grants aimed at strengthening the institutional environment for research serve the interests of both parties to this interdependency, as well as the interests of the American people in having the results of that research applied to improving their health.

You should be aware, therefore, of the 10-year decline in purchasing power of the Division's grants, compared with the impact of inflation on other components of the National Institutes of Health. Although there was some growth in the mid-1970's for the Division's Minority Biomedical Support Program, all of its other programs are less able now to provide the research resources vital for us to do our jobs than was the case in 1970. In 1969, the appropriation for the Division of Research Resources was $123.6 million. The 1981 appropriations level, expressed in 1969 dollars, is $75 million, or a 39 percent reduction in real terms.

The imbalance between resource and direct categorical research spending is nowhere more apparent than in the appropriations history for the Division's General Clinical Research Center and Biomedical Research Support Grant programs.

General Clinical Research Centers (GCRC)

By way of background it may be useful to comment on the indispensable role of this program in the continuing development of clinical research as a discipline. The carefully controlled measurements vital to clinical investigation cannot be carried out reliably on the general wards of the hospital, where understandably the staff is preoccupied with ministering to the immediate needs of ill patients. The GCRC, on the other hand, affords an optimal environment for controlled studies by providing a discrete unit with dedicated research beds and its own laboratory and dietetic support facilities, as well as a cadre of full-time nurses, dietitians, technicians, and social workers trained to cooperate in research. Each Center is, in effect, a miniature research hospital within a larger medical facility. In addition to serving as "laboratories" for the conduct of clinical research, the Center contributes to the training of clinical scientists, thereby enriching the national pool of qualified researchers. In addition, some residents, interns, and medical students also receive training in the Centers, or at least are exposed to research concepts and methodologies. It is generally agreed, moreover, that the quality of teaching tends to be enhanced through participation in the Center's activities by medical school faculty. Cases from the Centers are frequently presented at teaching conferences, with the result that students, house staff, and faculty learn directly and promptly about reseach advances. Other beneficiaries of Center training are the various categories of paramedical personnel who participate in the research procedures.

At Temple University we host an adult GCRC, and through an affiliation with St. Christopher's Hospital, we are associated intimately with a pediatric GCRC. I believe most medical school deans would concur in our view as to the value of these Centers in helping to maintain the research environment of their institutions. By providing investigators with controlled settings in which to conduct human studies, this program assures the availability of resources crucial to the conduct of clinical research. The multidisciplinary orientation of the Centers, their function in the training and recruitment of clinical scientists, and their effectiveness in translating new biomedical findings into clinical practice have an important impact on the health and well-being of man.

Appropriations, however, have been inconsistent with the formidable value of these centers. The Division's appropriation in 1969 included $35 million for the GCRC program. Funding for this program in 1980, however, was at a level of only $26 million, expressed in constant 1969 dollars. The program therefore had lost over one-quarter of its purchasing power. This loss is reflected in a reduction in the number of General Clinical Research Centers from 93 in 1969 to the 71 Centers proposed in the President's rescission for FY 1981. The problem, moreover, has been compounded by an inflation in hospital care costs recently exceeding 16 percent per year. In my judgement, a compelling case can be made for adding $3 million to the 1982 request merely to avoid the need to close down four of the 75 Centers currently funded by the Division.

Biomedical Research Support Grants (BRSG)

This type of grant provides flexible funds which, although subject to reasonable Federal guidelines, strengthen institutional health research capabilities. Let me describe from our experience at Temple the institutional impact of these grants.

First, these grants permit investment in young investigators who have not yet demonstrated their ability to conduct research independently. Young scientists without a national reputation can best be assessed by older and established investigators at the same institution. Compared with national review, local review is likely to be less costly, quicker, and more sensitive in judging a beginning investigator's potential. These funds have made it possible to assume limited risks in getting the promising beginner started -- often with a very modest investment.

Second, these grants have proved to be a stabilizing force for smoothing out funding discontinuties and modulating the stresses of the project grant system. It is thus possible to sustain programs judged by Study Section review to be meritorious, but for which grant awards either could not be made or were greatly delayed. The operation of many programs has been assured continuation through use of salary payments on an emergency or interim basis. Research efforts take time to develop, involving characteristically the recruitment and training of research teams; eliminating "bugs" from procedures; and, gaining experience with complex techniques. Also, the established team is itself a resource that is wasteful to disband. Our institutional obligations for faculty and staff engaged in research frequently would have been difficult to discharge if project support were abruptly terminated. BRSG funds have often provided protection against these threats to the viability and integrity of the institutional research base.

Third, the rigidities of project grant budgets constrict the investigator's freedom to explore new opportunities that emerge in he course of an investigation or to meet unanticipated research needs. BRSG has provided such needed flexibility. With these funds it has been possible to supply an item of equipment, a specially trained technician, computer time, supplies, etc. to meet emerging needs and opportunities. It can provide these as needed, in timely fashion and economically, without the necessity of agency review which is costly to the Government. The institutional research committee's intimate knowledge of local circumstances permits a stretching of these dollars by applying them where they are most crucially needed.

Although the BRSG program has become increasingly important to research institutions, it has, paradoxically, sustained a grave loss in purchasing power over the past 10 years. As I mentioned earlier, the Division's total appropriations in constant dollars have declined by 39 percent. Over the same period, however, BRSG funding has dropped in real terms from $60 million in 1969 to $20 million, a loss of two-thirds of its previous purchasing power. When staff and advisors of the Division recently developed a five-year program plan, it was agreed that one of the most important thrusts over the near term would be an effort to strengthen the BRSG program. As noted in the planning report, the objective is to increase BRSG funds from the present level of 2.1 percent of aggregate NIH research grants to 3.1 percent by 1986. As a first step toward that goal, I strongly recommend an increase of $15 million for this purpose in the coming fiscal year.

In closing, let me summarize the major points of my testimony. First, the advancement of biomedical research depends on investigators' access to research resources, such as specialized environments for research, advanced tools, etc. The Division strategically distributes its support in institutions across the country, so that a large and diverse group of biomedical scientists can share in these costly resources. Second, the purchasing power of appropriations for these research resource programs has declined markedly during the 1970's, while the purchasing power for most other components of the National Institutes of Health has at least kept pace with inflation. Given the essential role of research resources in the Nation's biomedical research enterprise, steps should be taken immediately to remedy past neglect in their support. A return to earlier funding levels in constant dollars, particularly for the BRSG and GCRC programs, is urgently needed.

Thank you very much, Mr. Chairman.

STATEMENT OF PATRICIA A. BOULWARE, RESEARCH ASSISTANT, GOVERNMENTAL ACTIVITIES OFFICE, UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

Although cerebral palsy is one of the most complex of the common handicapping conditions, scientists predict it can be eliminated entirely from the roster of childhood menaces. The United Cerebral Palsy Research and Education Foundation for the past twenty-five years has diligently worked toward this goal by awarding monies to scientific investigations in cerebral palsy and the training of personnel in the habilitative sciences.

Perhaps this effort is best exemplified by an excerpt from the UCPA 1980 Annual Report, concerning the prevention of premature births.

> "Research related to the prevention of premature delivery remained one of our most promising avenues of pursuit because of high risk that premature infants will develop neuromotor problems such as cerebral palsy. The Foundation was especially gratified when the Food and Drug Administration approved for marketing in this country the pharmacological agent Ritodrine, developed in Holland, as an effective agent in delaying delivery. The FDA action confirmed the importance of UCP's support of research into the use of relaxin, a natural substance secreted by pregnant women, which works in much the same way as Ritodrine. Both substances prevent premature delivery by relaxing uterine muscles. However, relaxin as a naturally occurring substance, is more likely to be free of unwanted side effects than a chemical product. The research UCP is funding at New York University under the direction of Gerson Weiss, M.D. has demonstrated the effectiveness of relaxin in laboratory experiments. The next step is to obtain a sufficient quantity of relaxin in order to test its effectiveness under actual chemical conditions."

Other areas of research that United Cerebral Palsy believe hold great promise today are: brain chemistry; improved obstetrical care for mothers who deliver high risk infants; care and treatment of prematures; prevention of or treatment for the infections that threaten newborns; drugs and vaccines to avert the diseases that affect the pregnant woman or her newborn infant or to help in their treatment. UCPA also has an interest in pharmacology and improving the functional ability of adults with cerebral palsy.

The significance of these areas of research lies in the fact that cerebral palsy is caused by damage to the parts of the brain that control movement. It occurs usually during the fetal period or around the time of birth, and its rate of incidence is especially high in premature infants. Since there is no known way of reversing the brain damage that causes cerebral palsy, preventing the condition from occurring in the first place must be the primary line of scientific attack.

UCPA RESEARCH CONCERNS RELATED TO THE NATIONAL INSTITUTES OF HEALTH

The Foundation has in the past and will continue to work closely with those Institutes within NIH which are involved in research into the prevention or amelioration of cerebral palsy. Considering the current state of the economy, it is becoming increasingly more difficult to secure private research funds. We believe that this is all the more reason for the federal government to continue its efforts in both research and training. Further, we are concerned that training programs may suffer as a result of budgetary constraints. While we understand the need to decrease federal spending, we are concerned that too many significant reductions in NIH training efforts will result in a drastic shortage of persons to conduct research which will one day lead to prevention of disabling conditions. With these thoughts in mind let us turn to the specific research concerns within NIH.

National Institute of Neurological and Communicative Disorders and Stroke

Research which is being done to prevent disabling conditions is certainly a priority of UCP. However, of equal importance is that research which is being done to reduce the impact of the disability. Such is the research which is being carried out at NINCDS. In the past UCP has supported research projects which are of interest to NINCDS. These projects include the development of surgical techniques to reduce the effects of cerebral palsy on the individual, the use of pharmacological agents related to the control of spasticity and athetosis, bioengineering contributions which improve the quality of life for persons with disabilities and prevention activities directed at eliminating the environmental causes of cerebral palsy such as trauma, accidents, chemical reactions and child abuse.

Recently NINCDS has been involved in research relating to the regeneration of the central nervous system. For a very long time researchers believed that such regeneration was a medical impossibility. It now appears that the nervous system can in fact regenerate, much like other cells of the body. Much more research is needed in this area. Further, while such research will directly effect spinal cord injury patients, such breakthroughs in neurology will ultimately effect persons with cerebral palsy. While this research may take a lengthy amount of time before any conclusive results are reached, we strongly believe it must be consistently supported.

- UCP Related Activities

UCP remains concerned about the quality of life of persons with cerebral palsy as exemplified by this excerpt from the 1980 Annual Report

"Technology that improves the functional abilities of persons with cerebral palsy and enables them to take part in community life, live independently and earn their livings is of increasing importance and interest to the Foundation. Of special significance is the work being done on communication aids for non-verbal individuals. As these are used more extensively, it is learned that persons thought to be retarded have been wrongly diagnosed because of their inability to communicate. In addition, being able to communicate improves the self-image of the non-verbal individual and helps to improve relationships with other people."

- Biomedical Research

UCPA also maintains a keen interest in various areas of biomedical research as recently demonstrated by awarding Dudley S. Childress, Ph.D., Director of the Northwestern University Rehabilitation Engineering Program, the Isabelle and Leonard H. Goldenson*Award for Technology and Medicine for his work in creating protheses for sensory and motor-disabled individuals, and for the development of environmental control systems for persons with disabilities.

As further stated in the Annual Report, "as bioengineers continue to create new ways to communicate, it becomes necessary to determine which method of communicating is best suited to a given individual. A simple communication board can supply the necessary words, but a truly effective communicating device can open up to a nonverbal person a social world from which he or she has been excluded by the inability to speak. At Helen Hayes Hospital in West Haverstraw, N.Y., Karin Wexler, Ph.D., is working under a UCP grant to develop a system that first evaluates the degree of ability a nonspeaking person has to communicate with others, and then determines which communicator will be most effective in helping the individual build on natural ability.

Another approach to helping the nonverbal is being taken by George A. Bekey, Ph.D., chairman of the Department of Electrical Engineering Systems at the University of Southern California at Los Angeles. Dr. Bekey is using mathematical methods to break down consistent patterns of sound made by a nonverbal person to the point where the sounds can be recognized by a computer. Once the computer recognizes the sounds, it converts them into words that can then be "spoken" by an electronic synthesizer. Ultimately, a machine that will do all this may be produced to sell for under $500."

*Leonard H. Goldenson, Chairman, UCPA Board of Directors

- Neuropharmacology

It has been generally recognized that some types of cerebral palsy can be greatly ameliorated through the use of pharmacologic agents associated with the control of specific functional problems. Perhaps the most important being the anti-convulsive medications. Medications to reduce athetosis (such as L-dopa) or spasticity (such as Dantralene or Valuim) have not been too successful. UCP recognizes neuropharmacological research is an area of vital unmet need and one in which NINCDS intervention, through its neurological Disorders Program would be most appropriate.

- Budget Recommendation

For several years NINCDS has experienced a dramatic erosion of its clinical research programs as a result of inadequate budget allocations coupled with an increasing inflation factor. A demonstrated need to expand and/or redirect the Institue's research effort will require additional funding to insure research quality and continuity.

For these reasons we join with the Epilepsy Foundation of America and others in recommending for NINCDS an F.Y. 82 appropriation level of $340.4 million.

National Institute of Allergy and Infectious Disease

The National Institute of Allergy and Infectious Diseases conducts and supports research contributing to a better understanding of the causes of allergic, immunologic, and infectious diseases and to the development of better means of preventing, diagnosing, and treating these conditions. Viral infections (viruses, bacteria, and other microorganisms) affecting fetal development are etiologically related to the causes of certain developmental disabilities such as cerebral palsy. Other diseases, such as varicella (chicken pox) and cytomegalovirus (CMV), are known causes of neurological disorders occurring early in life. The relationship of infections to neurological disability has only recently begun to be studied; perinatal infections and their effects on the developing nervous system, neonatal bacterial diseases, viral respiratory infections, and bacterial meningitis are all important areas under investigation.

Infectious disease is particularly important with the Influenza B which has been a problem in recent years. This type of influenza does not respond to the vaccine which is normally given to prevent the flu. This strain of flu is often followed by a disease called Reye's syndrome which affects young children. This disease can cause degeneration of the brain and also has a very high fatality rate. Realizing that Reye's syndrome can have a drastic effect on the central nervous system, UCP supports all efforts to find a cure for this disease.

- Budget Recommendation

Although the causal relationship between infectious disease and neurological disorders such as cerebral palsy is becoming increasingly recognized by the scientific community, NIAID has for a number of years suffered the lowest grant pay rate of all the National Institutes of Health. Given this context of chronic under funding, UCP joins with the Coalition for Health Funding in recommending an increase F.Y. 82 appropriation of $260 million for NIAID.

National Institute of Child Health and Human Development

NICHD has been involved in significant research in areas which pertain to children with cerebral palsy and their families. Of particular concern to UCP is the research which they have done on the assessment and evaluation of low birth weight infants and the follow along of infants who are born prematurely. As stated earlier, prematurity and low birth weight are two primary causes of cerebral palsy. Naturally, the sooner these children are identified the greater the chance there is of alleviating the disability.

- UCP Related Activities

As cited in our introduction, prevention of cerebral palsy is one of UCP's primary research emphases. In past years we have provided significant financial support for new and innovative treatments related to bilirubinemia (jaundice of the newborn) such as a new method of phototherapy (light treatment) and a variety of other prevention-oriented projects.

Prevention of prematurity is another fundamental concern. Babies born before term (particularly those weighing 3.3 pounds or less) are likely to have immature respiratory systems which cannot supply sufficient oxygen to the brain. This lack of oxygen is the basic cause of cerebral palsy. In the case of premature infants weighing between 2.2 and 3.3 pounds (1000-1500 grams), 15% of those experiencing respiratory distress and surviving will have central nervous system damage; for those under 2.2 pounds (less than 1000 grams) the figure increases to 35%.

In addition to research projects targeted at minimizing respiratory distress, the Foundation has supported efforts to utilize minicomputers to monitor and control the oxygen and carbon dioxide levels of premature infants; and to study the relationship between cerebral hemorrhage in newborns and construction of neural arteries, cutting off oxygen to the brain (as it would in adults). A research project of potential significance to individuals with cerebral palsy as discussed in the UCPA 1980 Annual Report is the PETT Scanner.

"A highly sophisticated piece of equipment that will undoubtedly prove of value in research related to cerebral palsy is the PETT Scanner (Positron Emission Transverse Tomography). PETT uses short-lived radioactive isotopes to measure metabolic processes in different parts of the brain. When a portion of the brain has been damaged, the metabolic process is affected and the results show up in pictures produced by a computer. By studying the computer pictures it is possible to determine which parts of the brain have been damaged, how and by how much. Repair processes can also be measured. Major use of the PETT scanner is presently with such conditions as cerebral-vascular hemorrhages and brain tumors. On of the scientists who has been given a federal grant for the construction and operation of a PETT scanner is Sid Gilman, M.D., a UCP grant recipient. Dr. Gillman anticipates that work of relevance to cerebral palsy will be forthcoming from this scanner in the continuation of his study of the mechanism of the central nervous system that produce and relieve excess muscle tone."

- Budget Recommendation

Because the NICHD contributes to our understanding of important aspects of child development, UCP joins the Coalition for Health Funding in recommending an increased F.Y. 82 appropriations level of $250 million.

NATIONAL INSTITUTES OF HEALTH (NIH)
(in millions)

	1980 Actual	1981 Appropriations	President's 1982 Request	UCPA Request
National Institute of Neurological and Communicative Disorders and Stroke (NINCDS)	$242	$255	$281	$340.4
National Institute of Allergy and Infectious Diseases (NIAID)	$215	$235	$248	$260
National Institute of Child Health and Human Development (NICHD)	$209	$225	$236	$250

STATEMENT OF DR. JOHN G. WEG, PRESIDENT, AMERICAN COLLEGE OF CHEST PHYSICIANS

I am Dr. John G. Weg, President of the American College of Chest Physicians. I am also Professor of Medicine and Physician-In-Charge, Pulmonary Division, University of Michigan School of Medicine. I am submitting these views for inclusion in the formal hearing record on behalf of the American College of Chest Physicians (ACCP). The ACCP is a professional medical specialty society of more than 10,000 physicians, scientists, and educators who specialize in diseases of the heart, lungs, and circulatory system.

Speaking for the membership of the College, I would like to emphasize that we very much appreciate this opportunity to offer our views to this important Committee in order to share our thoughts concerning FY 1981 rescissions for, and FY 1982 appropriations for, the National Heart, Lung, and Blood Institute (NHLBI) and the pulmonary activities of the National Institute of Allergy and Infectious Diseases (NIAID). At the outset, we recognize the substantial strains that have been placed on the Federal budget in recent years, and the need to exercise fiscal austerity in formulating a budget for Federal programs. Our recommendations are aimed at maintaining the momentum we have gained in combatting cardiovascular and pulmonary diseases within the past decade, and at alleviating the disincentives that have led to a drastic lack of interest among young physicians to enter academic and research careers.

National Heart, Lung, and Blood Institute

May I preface this statement by emphasizing that the ACCP fully supports the activities of the NHLBI. We are saddened that Dr. Robert Levy has announced that he will be resigning shortly his position as NHLBI Director; he has been a dedicated leader, an eminent scholar respected in the scientific community, and a capable and imaginative administrator.

Dr. Levy testified before this Committee just two weeks ago and highlighted the great strides that have been made in combatting cardiovascular and cardiopulmonary diseases. It was only a decade ago that the research mandate of the Institute was expanded to include the lung and that a concerted strategy to meet this very serious health problem was initiated. In our statement, we will highlight the pulmonary program because, with its statutory share of only 15% of the NHLBI budget, there is substantial need for at least modest growth in these programmatic activities. It is imperative that this Committee keep in mind that diseases of the lung have increasingly become a very serious national health problem. Lung diseases, the sixth leading cause of death in the United States, account for more than 100,000 deaths each year, 46 million days lost from work, and 40 million days of bed restricted activities; in addition, pulmonary disease costs the economy approximately $20 billion annually in lost productivity and wages and medical care costs. The NHLBI must be afforded the resources to continue its initiatives against neonatal respiratory distress syndrome, fibrotic and immunologic lung diseases, emphysema and chronic bronchitis, -- diseases which disable many millions of Americans.

A. Research

The NHLBI has been at the forefront of the biomedical research community's basic research effort to augment existing knowledge about the structure and function of the lung. ACCP enthusiastically endorses the NHLBI's support of research projects regarding: the mechanisms of lung tissue damage and repairs; oxygen toxicity and endothelial damage; pulmonary edema; lung inflamation; and the role of chemical, mechanical, and neural mechanisms in the control of ventilation.

In the area of diagnosis, the Division of Lung Diseases has supported numerous studies which have resulted in the development of new tests for detecting subtle alterations in pulmonary function. These tests can indicate the presence of early progressive chronic obstructive lung disease, such as emphysema, chronic bronchitis, and asthma -- diseases which afflict 14 million Americans.

We believe that the multitude of NHLBI research-oriented pulmonary programs have been effective and have saved, and will continue to save, billions of Federal and private health treatment dollars. It is also important to recognize that reductions in biomedical research support will not be compensated for by the private sector fund-raising community.

The Administration's proposed budget for FY 1981 and FY 1982 could have an adverse impact on NIH research programs. Approval by this Committee of the proposed $21 million rescission of already-appropriated FY 1981 funds would enable the Institute to support only 29.4% of its approved research grant applications, and under the

Administration's proposed FY 1982 budget, only 31.1% of approved grants. It was only a few years ago that the Institute was funding 40 to 50% of its approved grants.

Our recommendations, outlined in detail at the end of this statement, would provide for the funding of approximately 35% of approved grant applications, and would enable the Institute to pursue several new initiatives, including: basic research on the respiratory muscle fatigue that results in respiratory failure; expanded research on immunologic methods for early detection, development, and testing of synthetic protease inhibitors and inhibitor replacement therapy for treatment; important epidemiologic studies to more effectively define and detect risk factors, to collate and compare acute- and long-term effects of smoking in males and females, and to ascertain the efficacy of treatment of mild respiratory dysfunction detected in population surveys; and enhanced prevention education and control research projects.

Our fiscal recommendations for the research grant and contract line of the NHLBI budget would enable the Institute to maintain its support for several other vital programs: Special Centers of Research; Heart, Lung, and Blood Research and Demonstration Centers; and Pulmonary Faculty Training Awards, to name a few.

B. Manpower Training

Congress has, during recent years, made a number of improvements in the Nation's principle biomedical research training mechanism, the National Research Service Award (NRSA) program. We will be making a number of recommendations to the House and Senate Health Subcommittees when they consider reauthorizing the NRSA mechanism this spring. The tax burden on trainees has been eased, and the Secretary has increased trainee stipends. These improvements are designed to provide an incentive for young physicians and scientists to enter the arena of research, and we applaud them. But the bottom line for the success of the NRSA program is still full-time equivalent trainee support. The Administration has proposed a rescission of NIH research training funds. Approval of this rescission of FY 1981 funds would reduce the number of NHLBI trainees by 131 and delete traditional institutional support and indirect costs. This will exacerbate an already disturbing trend, and transmit a loud and clear message to future researchers that the Federal government is unwilling to support, or appreciate, the sacrifices which the young clinical investigator must undertake in order to pursue a research career. We recommend that no FY 1981 research manpower training funds be rescinded and that sufficient funds be provided in FY 1982 to enable the Institute to increase by 10% the number of full-time equivalent trainees.

During the past decade, the number of NHLBI trainees who are clinical investigators (i.e., trainees with an M.D. degree) have declined by almost 70%. Substantially hard-hit by the Administration's budget are vital programs (such as Clinical Investigator Awards, New Investigator Awards, and Research Career Development Awards), which are designed to support young researchers during their transition from post-doctoral fellowship status to independent investigatorship. Our proposed budget would provide for modest growth in these vital training mechanisms; please note that these non-NRSA programs are included under the research line of the NHLBI budget.

C. Other NHLBI Programs

The American College of Chest Physicians urges this Committee to support modest increases for the clinical trials and prevention education and control programs of the NHLBI. The Seventh Report of the Director, NHLBI highlights a number of important clinical trials and prevention-related activities which are deserving of support, including projects to evaluate the strategies of health education that encourage compliance with medical treatment and advice, to assess and enhance the use of spirometry to detect and manage chronic obstructive pulmonary disease in large populations, and to study pulmonary rehabilitation in community hospitals.

National Institute of Allergy and Infectious Diseases

ACCP recommends that $260 million be appropriated to the National Institute of Allergy and Infectious Diseases. NIAID is sponsoring important research in influenza and other diseases with respiratory implications, such as influenza viruses, respiratory syncytial and parainfluenza viruses, pneumonia, otitis media, and meningitis. The Institute's research with regard to viruses embodies great potential to expand our knowledge of degenerative chronic diseases, such as asthma, which afflicts more than 6 million Americans. Our recommendation would enable the Institute to fund approximately 35% of its approved research grant applications.

Conclusion

In the area of cardiopulmonary research, we are on the verge of what NIH Director, Dr. Donald Frederickson, characterized recently in the New England Journal of Medicine as a "scientific revolution". The biomedical research community is making significant strides in attaining what we all stride for as the most cost-effective health goal -- prevention. The combination of research budget cuts and training disincentives are transmitting a resounding message to our future corps of research scientists -- that the Federal government, which supports the vast proportion of biomedical research, is turning its back on a revolution which could yield billions of dollars in health cost savings in just a few years.

On behalf of ACCP and its more than 11,000 members, I would like to convey our deepest appreciation for your having afforded us this opportunity to share our views and judgements with you.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

(in millions of dollars)

	FY 1981 Administration Budget	FY 1980 ACCP Recommendation
RESEARCH GRANTS		
Includes Noncompeting continuous, competing continuations, SCORs, Research and Demonstration Centers, Pulmonary Faculty Training Awards	414.0	436.0
TRAINING PROGRAMS	24.7	39.0
RESEARCH AND DEVELOPMENT CONTRACTS	61.0	66.0
Includes Clinical Trials and Prevention, Education and Control Programs		
INTRAMURAL LABORATORY AND CLINICAL RESEARCH	49.5	49.5
DIRECT OPERATIONS AND PROGRAM MANAGEMENT	33.7	33.7
TOTAL	582.9	624.2

STATEMENT OF AMERICAN DENTAL ASSOCIATION

The American Dental Association understands the Administration's and Congress' commitment to reduce the growth of federal spending. It is evident that government at all levels must be responsive to the mandate of the people to reduce growth in government spending. However, the review and evaluation of what federal dollars be spent on which public programs must be undertaken with equanimity and care.

This evaluation process will be particularly difficult in a departmental budget which is largely devoted to entitlement expenditures mandated by law.

The bulk of spending reduction in the Health and Human Services budget must come from a relatively small number of projects which are subject to the annual appropriations process. The Association nevertheless believes that certain spending reductions can be facilitated if expenditures are limited to those programs where a federal presence is justified and where efficiency and effectiveness can be demonstrated.

National Health Service Corps

The legislation which established the National Health Service Corps was designed to encourage the establishment of private practices in remote areas by means of temporary federal support. For the last several years, however, this emphasis has shifted and now the majority of Corps dental placements are in community health centers or at other fixed sites. This approach not only penalizes those underserved communities without health facilities, but establishes a permanent federal presence in direct competition with local providers.

The Association supports the President's proposal to eliminate funding for new NHSC scholarship awards. Furthermore, we respectfully request that those scholarship recipients currently in the pipeline be directed to serve in underserved areas with greatest need (priority 01 and 02).

Health Maintenance Organizations

The American Dental Association supports the Administration's proposal to phase-out federal assistance for health maintenance organizations.

The Association supports experimental efforts to develop new and effective ways of providing health services, but believes that such alternative systems should be evaluated fairly and should succeed on their own merits.

HMOs have enjoyed access to federal subsidies for nine years -- ample time to establish their viability. Continued government assistance for HMOs is unfair to practitioners who must compete with federally subsidized delivery systems. It is also unfair to the taxpayer who is being forced to pay for health delivery programs that should be self-supporting.

Health Professions Education

Given the prospective termination of capitation grants to the health professions schools, it becomes even more imperative that student financial assistance be increased.

In the absence of federal institutional support, dental schools will be forced to increase tuition costs, or risk reducing the quality of the dental education program by increasing class size or cutting back facilities.

It is currently estimated that the annual dental education expense (exclusive of living costs) exceeds $12,000. It is virtually impossible for a student to raise such a sum through part-time and/or summer employment. (Besides, many schools proscribe summer programs after the first year.) It is also unreasonable to expect that parents and families of dental students can sustain such costs.

The cost to establish a dental practice (after at least four years of professional school) currently averages between $40,000 and $50,000. Added to educational expenses, the new dentist faces a financial obligation approaching $100,000 before he or she sees his or her first patient.

The Administration would have students assume an increasingly higher percentage of their educational costs even though such a policy would result in contributing to the twin problems of rising health care costs and geographic maldistribution of providers.

The American Dental Association strongly urges the committee to appropriate not less than $50 million for health professions student loans.

Dental General Practice Residencies

The Administration proposes to eliminate funding for dental general practice residencies. This is surprising in light of the Administration's professed desire to "target resources on meeting national priority (health) training needs, such as primary care professionals."

The Association strongly recommends continued support for dental general practice residencies.

Dental Research

The Administration's FY 1982 budget requests $75 million for the National Institute of Dental Research. This represents a small increase over FY 81 appropriations, but not enough to keep pace with inflation much less realize an actual increase.

As the committee considers appropriation levels for the National Institutes of Health, members should bear in mind that unlike the other institutes, NIDR supports most of the dental research conducted in this country. Conservative estimates indicate that 85 percent of total dental research spending since World War II has come from NIDR. Little private funding is available at this time.

Dental disease is progressive and irreversible; therefore, prevention is the key element in the dental research strategy. NIDR has recently started human clinical trials for an anit-caries vaccine that has been developed over the last several years. Like fluoridation before it, the new vaccine could further reduce the incidence of caries in children.

In order to support adequately prevention-based research efforts in dentistry, including continued support of research training, the American Dental Association recommends that not less than $85.6 million be appropriated for the National Institute of Dental Research.

Improved technology resulting from applied research of the type conducted at the National Bureau of Standards has saved millions of dollars in dental costs, and has greatly improved the productivity of dentists. For example, the high-speed hand piece, the panoramic x-ray, and composite filling materials developed there have been major cost-saving achievements. The American Dental Association strongly urges Congress to continue support for NBS research programs.

Dental Disease Prevention

The American Dental Association strongly urges Congress and the Administration to continue efforts to reduce dental decay in children by appropriating $10 million for the fluoridation of community water supplies.

The preventive benefits of fluoridation have been well documented for over 40 years. Fluoridation has been endorsed as the most beneficial and cost-effective preventive dental health measure by every major health organization in the world.

Studies have shown that children living in communities with fluoridated water supplies experience a 60-64% reduction in cavities. The Surgeon General of the United States recently pronounced the following: "Fluoridation is the most effective, least costly public health measure for preventing tooth decay -- one of the most prevalent health problems, yet only three of every five persons who could be provided the benefits of fluoridation now receive them."

The American Dental Association strongly urges Congress to sustain support for a program whose cost and health benefits have been made so obvious over the last several decades. The ADA requests a $10 million appropriation for community water fluoridation grants administered by the Center for Disease Control.

Joint Statement of Riley Regan, Director, New Jersey Division of Alcoholism and President, National Association of State Alcohol and Drug Abuse Directors; Kenneth L. Eaton, Administrator, Michigan Office of Substance Abuse Services; and Anne Robertson, Director, Mississippi Division of Alcohol and Drug Abuse

Thank you for the opportunity to submit the following statement for the record in connection with hearings held March 16th by the Senate Subcommittee on Appropriations for Labor, HHS and Education. This brief statement will focus on the proposed rescission of the alcohol and drug abuse formula grant programs in the FY 81 ADAMHA budget and the drastic impact such a rescission, if approved by the Congress, will have on the provision of alcoholism and drug abuse services throughout the nation.

Of the total $746 million proposed for rescission in the FY 81 HHS budget, rescission of the alcohol and drug abuse formula grant program - $80 million - represents over 10% of the total. If the proposed rescission of $50 million for the alcohol formula grant program is approved by Congress, NIAAA's services budget will be decreased 68%; NIDA's services budget will be reduced by 19% if the $30 million for the drug abuse formula grant program is rescinded. The State alcohol and drug abuse authorities support attempts to reduce the Federal budget deficit and accepted reductions in program funds last year when other health areas received increases. However, total elimination of these important programs will destroy the still tightly funded service network which it has taken the Federal and State governments over a decade to develop. Combined with the Administration's current proposal to consolidate categorical health programs into one or more block grants and reduce the funds available by 25% - the alcohol and drug abuse systems are facing major losses at a time when service needs are showing no decline.

Only seven months ago the House Subcommittee on Appropriations for Labor, HHS and Education supported and recognized the importance of these formula grant programs to the alcohol and drug abuse service delivery network by restoring the programs to the ADAMHA budget after the former Administration proposed total elimination in the FY 81 budget revisions submitted in March 1980. The basis for the Subcommittee's decision was stated in the Committee report with the following language:

> *"The Committee is willing to support a policy which suggests that the State should pick up a larger share of the cost of supporting State-run treatment programs. It could not, however, accept the total elimination of their grants on such short notice as proposed in the March (1980) revision to the budget. This would have done irrepairable damage to a program of abosutely essential services... it is clear that many persons would lose services in such an abrupt transition."*

Although the program was restored by both Houses of Congress and support for the formula grant program was reinforced in two subsequent continuing resolutions, the former Administration in its January budget request once again elected two renege on its commitment to the State alcohol and drug abuse authorities made months earlier by proposing rescission of the program. The present Administration also chose to include rescission of these crucial program funds in its March 1981 rescission request.

The reasoning behind the past and current Administrations' continuing attempts to eliminate this program is suspect, if not completely illogical and inconsistent. Under the Carter Administration, the Office of Management and Budget had the erroneous notion that these alcohol and drug abuse formula grant programs were similar to general revenue sharing for the States. In fact, these programs were not created in the mold of general revenue sharing, nor have they been implemented as such. These programs were DESIGNED BY CONGRESS to support services provided directly and indirectly to the millions of Americans who are in need of assistance for problems of alcohol and drug abuse.

These programs support planning activities by the State alcohol and drug abuse authorities to enable them to better meet the needs of the citizens and ensure the provision of a wide range of supportive services. These programs supplement treatment and prevention efforts within the State and ensure that the needs of special populations such as the elderly, women, minorities and youth are able to obtain comprehensive alcohol and drug abuse services. Critics of the formula grant program have, in the past, erroneously stated the dollars allocated to the States under this program are merely supporting the cost of State administrative costs and personnel.

In truth these funds are the only discretionary dollars for alcohol and drug abuse services allocated to the States and support numerous prevention and treatment efforts. The most recent information concerning distribution of the alcohol formula grant dollars for the most recently completed fiscal year reveals the following programmatic distribution: 55% for treatment, 17% for prevention/intervention, 13% for planning, 3% for administration, 3% for training, 2% for research and 7% for miscellaneous services. The FY 80 drug abuse dollars are distributed by the States in a similar manner: 39% for treatment, 27% for prevention, 13% for planning, 8% for administration, 6% for research, 5% for training and 2% for criminal justice services.

The current Administration's support for the inclusion of the formula grant rescission in its recently submitted revised budget request for FY 81 appears to rest on two points: first, a general tenet that all FY 81 rescissions proposed by the former Administration's January FY 81 rescission request shall also be included in the present Administration's rescission request; and second, the false argument that since the formula grants awarded to the States may be spent over a two-year period the majority of States are presently utilizing their FY 80 formula grant awards in their FY 81 budget cycle. The belief by the Administration that no services or programs will be lost or disrupted if the rescission is approved by Congress is an incorrect and dangerous assumption. Already many of the over 1,000 treatment and approximately 600 prevention/intervention programs which normally receive formula grant dollars are facing a critical funding shortage. These programs and the services which they provide will have to be reduce significantly and in many cases, halt completely, because the FY 81 formula grant dollars, committed seven months ago by Congress to the States, are proposed for rescission.

Not only will services directly funded by formula grant dollars be eliminated, but also the State and locally funded services for which formula dollars have been the catalyst will have to be reduced. Once the State service network is disabled, it will require a massive investment and many months of effort before the network could be rebuilt. The apparent short term cost savings will result in long term costs to Federal, State and local governments and ultimately the American taxpayers.

In addition to the current 12 month lapse in award of the FY 81 formula grants, under which many States are currently attempting to operate, State alcohol and drug abuse authorities have been operating under an additional three month gap in funding since the mid-70's when the Congress revised its budget procedures. At that time, when the starting date for the Federal fiscal year was changed from July 1st to October 1st a three month transition period was incurred - July 1, 1974 to September 31, 1974 - for which zero appropriations for the alcohol and drug abuse formula grants were received by the States. The Administration never introduced legislation to appropriate funds during the transition quarter and therefore Congress never provided appropriations of Federal dollars for this period.

In addition to this three month gap of funding, the Department of HHS has often operated under a continuing resolution for reasons having nothing to do with alcohol and drug abuse resulting in a delay of grant awards for a six to twelve month period at times. Under these circumstances, when both Houses of Congress passed the continuing resolution last Fall which provided funding for HHS and restored the formula grant program to the FY 81 budget, State alcohol and drug abuse authorities included these formula grant dollars in their State budget for FY 81, expecting to receive these funds in the next six to nine month period. Congress made a serious commitment to the States when the program was restored in the FY 81 budget and they should honor immediately this commitment.

It is impossible at this late date in FY 81 for a significant majority of the State legislatures to revise their already tight budgets to make up for this lapse in funding. Some State legislatures have adjourned; for the legislatures still in session, by the time these deliberations are completed it will be too late to make significant changes in their States' budgets.

Even if the Administration's block grant proposal for general health services is passed by September 31, 1981, the Federal appropriations process remains, Federal regulations and implementation of the program within the Department of HHS must take place, and State systems and appropriations must be revised to reflect the new grant system. Certainly, all of these complex decisions cannot be completed and implemented by the end of FY 81. The result may be another crucial gap of funding to the State alcohol and drug abuse service network in the first half of FY 82.

Rescission of the FY 81 formula grant funds will also jeapordize the State alcohol and drug abuse constituents ability to compete with the other programs included in the block grant to obtain a fair share of the dollars. Of course, the most obvious inconsistency in the proposed rescission is that the proposal is in direct conflict with the publically expressed desire to promote increased responsibility and flexibility in the States in providing health and social services. In fact, the rescission is a step away from a carefully implemented grant consolidation program rather than a step toward increased State flexibility.

STATEMENT OF AMERICAN PSYCHIATRIC ASSOCIATION

The FY 82 Reagan budget request refocuses the allocation of Federal funds to "target resources on meeting national priority training needs...". In addition, the HHS background material states that the "principal reason for decreasing aid (via the FY 81 rescission request) is to remove incentives for expanding the supply of health professionals, especially in those fields where the national supply is adequate or anticipated to be in surplus within the near future..." The principal Federal mechanism which has been used to support the psychiatric training programs has been Section 303 of the Public Health Service Act, administered by the Psychiatry Education Branch, of the National Institute on Mental Health, ADAMHA. The HHS budget justification for ADAMHA states that "clinical training is proposed for elimination because Federal subsidies for such training are no longer essential." However, the health professions section of the same HHS budget justification endorses the targeting of health professions training resources on meeting national priority training needs. The final report of the Graduate Medical Education National Advisory Committee (GMENAC) projected a shortage of almost 13,000 psychiatrist (an approximate 30% shortfall) by 1990. Other medical fields for which there are budget requests for continued or new funding are either projected to be in balance or in surplus in 1990. Similar shortage conclusions are documented by the Rand Corporation, the Heritage Foundation, the President's Commission on Mental Health (PCMH), and the FY 1980 Report to the Senate Appropriation Committee. We believe that either categorical authority of funding preference be given to training in shortage specialties and/or disciplines in relation to the severity of documented shortage and service need. This recommendation is both consistent with the overall HHS health professions training rationale and the well established shortage of psychiatrists. Such recommendation is not existent in either the ADAMNA or Health Resources Administration budget justifications relating to Federal support for training assistance, and urge that such change be made.

We are gratified that the Mental Health Systems Act (P.L. 96-398) acknowledges the severe shortage of psychiatrists, endorsing the conclusions of the PCMH and other entities, which recommended increased support of psychiatric residencies. The proposed phase-out of the NIMH clinical manpower training program contradicts the noted credible sources of documentation of a severe shortage of psychiatrists to meet the treatment needs of the 10-15% of the American population with significant mental illness disorders.

Coupled with the need for training funds for psychiatry training programs are changes in reimbursement mechanisms (e.g. Medicare, Medicaid) so that time-based specialties, such as psychiatry, are not penalized at the expense of procedure- and technology-based specialties which are largely inpatient-oriented, the service components of which underwrite a large proportion of the costs of related residency programs.

In addition, targeted incentives in student loans or service-related scholarships tied either to preference for individuals interested in entering shortage specialties or tax incentives, such as an interest differential, should be seriously examined.

The APA continues to be concerned with the entry and residency training of foreign medical graduates. We believe that H.R. 2056 is a reasonable approach to weaning the U.S. from an unreasonable and unfair (in the "brain drain" context) dependence on foreign trained physicians. The only section which causes us some concern is the extension of the "substantial disruption" waiver provision until December 31, 1981, without requiring any increased obligation for an expedited independence of foreign trained physicians.

FY 82 APPROPRIATIONS FACT SHEET

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

THE AMERICAN PSYCHIATRIC ASSOCIATION

The APA has three major concerns with the FY'82 ADAMHA budget:

1. Research resource allocations for ADAMHA (mental health, alcohol and drug abuse research) are not only insufficient but also inequitable when contrasted to funding for NIH's research activities;
2. The phase out of NIMH clinical manpower training support will exacerbate documented shortages of psychiatrists; and
3. The inclusion of the Mental Health Systems Act (MHSA) in a health services block grant to the states will cause inappropriate institutionalization and the mentally ill will be swept up in the criminal justice system, all cost ineffective.

MENTAL HEALTH RESEARCH

The $3.521 billion NIH research budget suffered a 3.5% cut in the FY 81 Reagan budget revision. The NIMH comparable research component (extramural and intramural research and research training) was cut 9.1% in the same FY 81 Reagan budget revision. Thus, in order for there to be equity with the NIH rescission, $9.635 million of the $15.6 million recommended for rescission needs to be restored for NIMH research, so that it will total $165.635 million.

For FY 82, NIH research is slated for a 6.6% increase for total $3.762 billion. NIMH research activities, however, are only recommended to receive a 0.2% increase and total $176.567 million. Thus, there needs to be an increase of $10.9 million over the FY 81 recommended rescission level in order to have equity with NIH research levels in the FY 82 budget.

The research activities of NIH and NIMH are complementary and the grant review mechanism permits only highly qualified awards to be made.

CLINICAL MANPOWER

The FY'82 Reagan budget justification for NIMH clinical manpower training support states: "Clinical training is proposed for elimination because Federal subsidies for such training are no long essential." This is in direct contradiction to the realities of what historic Federal support has accomplished and for which it was designed. For example, as cited recently by the Heritage Foundation, the FY 1970 appropriation for NIMH clinical manpower was, in constant dollar terms, 62% more than the FY 80 funding level. In programmatic terms, there has been a five fold decrease in support of psychiatry training programs during the past decade, and the number of American medical graduates (AMGs) entering psychiatry residencies dropped from 12% to 3.2%. Such a decline was directly related to the significant decline in Federal support. In 1980, about 550 AMGs entered psychiatric residencies. If even 10% had continued to enter these programs (which would have required increased appropriations), the severe shortage currently being experienced by psychiatry would now be much less. Instead, the shortage will be exacerbated with the proposed elimination of clinical manpower training support.

In order to arrest the further decline in AMGs choosing psychiatry and begin to train the number of psychiatrists needed to treat 20-30 million Americans documented as in need of treatment for mental illness, the rescission request for NIMH clinical training in FY 81 ($4,938,000) should be disapproved. Likewise, the $8,552,000 reduction requested in the FY 82 revised budget request should be disregarded. The FY 81 continuing resolution of $23.1 million should be the absolute minimum level for FY'82.

Integral to the rationale for continuing and enhancing Federal aid for psychiatric clinical manpower training programs is the reality that the reimbursement system rewards technology and procedure oriented specialties and, therefore, penalizes time-based specialities, such as psychiatry. One of the reasons the technology and procedure-based specialities have not suffered and have not required Federal or other outside support is due to their largely inpatient-orientation. Such service components underwrite the costs of related residency training programs. These mechanisms and models have the effect of penalizing psychiatry which even has shifted training and treatment largely to ambulatory outpatient settings based on new treatment modalities, recommendations of the President's Commission on Mental Health, Congressional initiatives and third party payment changes. Psychiatry is now suffering because of the success of initiatives such as deinstitutionalization and its responsiveness to other national shifts in health care policy and patient needs.

MHSA/BLOCK GRANT

It is well established that when essestial community support mechanisms necessary and appropriate for the care of the mentally ill, as contemplated by the Mental Health Systems Act (MHSA) are not available, resources for these extremely vulnerable populations -- a truism if the MHSA is turned into a health services block grant -- individual states, with few, if any, exceptions, will have no alternative but to turn to more costly and inappropriate institutionalization. Indeed, it is further well documented that without such community support, the mentally ill will be tragically swept up into the most inappropriate and most costly criminal justice system.

STATEMENT OF COALITION FOR ALLIED HEALTH PROFESSIONS EDUCATION

The Allied Health Community

The Allied Health professions are heterogeneous in the extreme, differing in the competencies they require, their respective requisite educational preparation, the scientific foundations for their knowledge bases, and the clinical and educational roles which they play in the nation's health-care delivery system.

Required competencies vary from the performance of relatively routine tasks to the highest levels of education and service-delivery administration and the generation of new knowledge through research. Similarly broad is the range of educational preparation the Allied Health professions require -- from limited post-secondary training to postdoctoral study. The time required for such preparation ranges from several months to more than a few years. The scientific foundations of Allied Health profession expertise range from the biological and chemical sciences (e.g., clinical laboratory professionals), to the social sciences (e.g., social workers and clinical psychologists), to combinations of the physical and social sciences and the humanities (e.g., speech pathologists, rehabilitation counselors).

Some Allied Health professionals are involved primarily in institutional patient care, others in community health promotion and protection, still others in health-care research, manpower training, and education and service delivery administration. The range of Allied Health services includes:

- emergency services (e.g., emergency medical technicians, physician assistants);
- reception and screening (e.g., medical and dental secretaries, medical office assistants);
- initial evaluation and diagnosis (e.g., audiologists, physician assistants, dental hygienists, mental health technologists, medical social workers);
- continued assessment as part of treatment (e.g., physical therapists, occupational therapists, respiratory therapists, speech pathologists, audiologists, dietitians);
- testing (e.g., medical laboratory personnel, radiologic technologists, ultrasound technical specialists, nuclear medicine personnel, cardiology equipment personnel);
- acute care therapy (e.g., operating room technicians, obstetrical assistants, surgeons' assistants);
- long-term care therapy (e.g., occupational, physical and other therapists; personnel in mental health and social services, counseling, speech pathology, audiology, nutrition);
- medical instrumentation (e.g., radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, opthalmic dispensers, dental laboratory technicians);
- community health promotion and protection (e.g., nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers);
- environmental health promotion and protection (e.g., sanitarians, environmental health technicians, sanitarian aides, environmental engineering assistants);
- control and elimination of hazards in an institutional or industrial setting (e.g., audiologists, health physicists, health care facility housekeepers, industrial hygienists);
- health systems management (e.g., hospital administrators, health planners, medical records personnel, medical computer specialists);
- research and development (e.g., biomedical engineers, biostatisticians, epidemiologists, toxicologists, public health scientists, and researchers in every occupational category).

An essential feature of Allied Health education since the 1960s has been its rapid change and expansion, characterized by the following three major ingredients: First, there has been a tremendous growth in the number of programs, particularly in collegiate settings, which has paralleled the great expansion of two-year colleges and the growing popularity of vocational programs (in 1966, there were an estimated 2,500 collegiate programs; today there are over 8,000); second, the distribution of programs has changed -- hospitals and other health-service settings still play an important role, but the greatest program growth has occurred in such other settings as medical centers and universities, two-year colleges, vocational technical institutes, and private career schools; third, a dramatic expansion of knowledge and skill requirements has led to increased diversification of educational requirements.

In 1976, the latest year for which there is adequate survey information, there were about 14,000 formal postsecondary programs for Allied Health personnel. Of these,

- 52 to 54 percent were in collegiate settings,
- 33 to 35 percent were in hospitals
- 10 to 12 percent were in postsecondary non-collegiate institutions, and
- one percent were in the armed forces.

Over half of the nation's 3,000 higher education institutions have at least one Allied Health program. Such programs are contained in about 90 percent of the nation's research universities and doctoral-granting institutions, as well as in large proportions of comprehensive colleges and universities, free-standing medical centers, and two-year colleges. Significantly more than half of all Allied Health programs in collegiate institutions award degrees at the baccalaureate or higher level.

It may be important to point out here that these patterns of education for the Allied Health professions have grown out of practice needs, rather than from abstractly determined sets of values. Thus, the history of Allied Health education, brief as it is, is closely related to the history of the occupations themselves. The burgeoning of the Allied Health professions and of Allied Health education is the product of increased and increasing health-service demands and the explosive growth in health science and technology.

Manpower data collection is not what it might be -- what we hope it can and will be -- in the area of Allied Health. Still, we can say with reasonable assurance that, as of 1978, an estimated 3.5 million individuals (nearly 66 percent of the total health-care work force) could be classified, in the broadest sense, as Allied Health practitioners. The core of this population -- the professions in which the federal government has invested the bulk of its Allied

Health manpower-training funds and which, generally, require collegiate preparation ranging from the associate degree to the doctorate -- has grown from 442,000 in 1966 to approximately 1,026,000 in 1978. This 132-percent rate of growth compares with a 76-percent growth rate for all health professionals.

Yet despite this growth, the Department of Health and Human Services Bureau of Health Manpower (Health Resources Administration)* tells us that there are still clear and significant national Allied Health manpower shortages in such professions as audiology, speech pathology and respiratory therapy. And though the data is not definitive, it also appears to the Bureau that there still may be national shortages of dietitians and dietetic technicians, radiation therapists, physical therapists, occupation therapists, and formally-trained dental assistants.

The Bureau goes on to report that, even in professions in which the overall national supply appears to be adequate, local or transitory shortages continue and employers across the country encounter difficulties in filling "critical Allied Health positions" requiring highly qualified professionals and exceptional skills.

Federal Support of Allied Health Education

Federal support for Allied Health manpower training was first authorized in 1966 by the Allied Health Professions Personnel Training Act. During the first four years of operation under its authorities, the statute put primary emphasis on increasing the number of training programs and professionals. In the early seventies, however, the statute was amended, its emphasis shifted: Basic improvement grants, which encouraged the establishment of new scholastic programs, were abandoned in favor of new focuses and initiatives, relating more to the provision of quality Allied Health education and health service than to the production of increased numbers of Allied Health professionals. The shift clearly was occasioned by public economic policy, and not by evidence that manpower needs had been met -- there were at least as many "significant" national professional-area shortages at the start of the seventies as there are today.

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*Report (to Congress) on Allied Health Personnel. DHHS Pub. No. (HRA)80-28.

The new funding focuses on special educational projects for Allied Health training programs (one special project focus addressed the need for the "establishment of new roles and functions for Allied Health" personnel), on faculty development through a mechanism called "advanced traineeships", and on the recruitment to the Allied Health professions and retention of ethnic minorities-group members.

Funding authorizations which followed the shift from the early basic improvement grants to the special target grants and contracts were moderate, to say the most. But this moderate support soon became virtually no support at all. In fiscal year 1973, for example, Congress provided $30.2 million to support Allied Health planning, development and operation of such (sections 796, 797 and 798) projects as the establishment of regional systems for coordinating and managing Allied Health training; of new and improved methods of credentialing Allied Health Personnel; of recruitment, training and retraining programs; of career ladders and other programs of advancement; of continuing education programs; of faculty training instituės; and of ethnic minority-group member recruitment. Two years ago, following a Carter Administration call for zero funding of Allied Health manpower-training programs and projects, the Allied Health community was able to win congressional support for a $10 million fiscal 1980 appropriation for these Part G (Title VII) initiatives (one-third of that amount subsequently was rescinded). Last year, the Carter Administration again called for a zero funding level. After Congress appropriated $6.7 million, President Carter called for a rescission of all of that amount and the new Administration appears similarly inclined.

The rationale of both Administrations for these terminal reductions makes no sense at all. Spokesmen for both Administrations have listed cost containment, the delivery of services to unserved and underserved areas of the country, disease prevention and health promotion, and the involvement of ethnic minority-group members in health-care education and service delivery as the major national health-care objectives. Yet, the Carter and Reagan Administrations have urged Congress to refuse any support for that segment of the health manpower population which is best prepared and best able to address these objectives.

Both Administrations also have said that, inasmuch as there are no manpower shortages among the A-lied Health professions, "continued federal involvement in basic Allied Health training support" is unwarranted. The argument both denies and defies the reality of the Report of the federal government's own health-manpower agency, which not only makes a "case for continued Federal activity on behalf of allied health personnel," but also lista a relatively large number of key Allied Health professions in which there are "significant national shortages." But more -- both Administrations have overlooked the fact that federal Allied Health manpower-training funding is expressly intended by statute for special-target projects and not for basic education support. Indeed, such basic support hasn't been available to the Allied Health professions for the better part of a decade!

Some might argue that the $283 million invested by the federal government (since 1967) in Allied Health manpower training is not only a substantial amount, but an appropriate amount as well. Substantial it well might be; appropriate it most assuredly is not. The $283 million figure -- the federal government's total 14-year commitment to two-thirds of the nation's health-care workforce -- represents merely four percent of the total federal investment in health-manpower training and development. From its beginnings, Allied Health has been relegated by the federal government to but a cubby hole in the great mansion of health-care education. Today, there's an eviction notice on our small door. We hope this Subcommittee will tear down that notice and, in doing so, give notice of its own that Allied Health can, must and will be counted on by the federal government as a major partner in the development of an effective manpower-training and service-delivery effort.

Bureau of Health Manpower Recommendations

The Coalition believes that the federal government must assume a leadership role in helping fill what HRA's Bureau of Health Manpower terms as "significant national (Allied Health) shortages."

In addition, we see a major federal responsibility in the fulfillment of these of the Bureau's Allied Health related recommendations:

1. "Information including statistical data on allied health personnel requires continued improvement, by larger investments and coordinated activities...

   "Particularly, data are needed with which to determine the nature and extent of 'critical vacancies' and specific skills shortages, and to plan appropriate local, State, regional, or national education.

   "Better data are needed on minority participation in the work force.

2. "Special attention to the allied health personnel problems of small health care institutions is required, to ensure that regulatory and other constraints do not interfere with access to and the quality and continuity of patient care. Additional resources are needed with which to investigate the nature, extent, and impact of these problems, and to devise solutions as may be necessary.

3. "The cost-saving potential of more efficient use of allied health personnel should be thoroughly explored through well-designed and controlled studies carried out in various work settings and not hindered by current legal limitations on the use of personnel.

4. "As personnel standards are changed, training programs must be revised. This requires national coordination and encouragement.

5. "As manpower standards change, personnel working in the field who cannot meet new and more rigorous qualifications must be provided with opportunities to improve their competencies. Support to develop training materials and procedures that will reach the employed work force is necessary.

6. "Methods of testing of individuals to determine competency in the health field require improvement, through additional research, development, and validation, with Federal leadership.

7. "To the extent necessary to ensure adequate numbers of these personnel equitably distributed among and within States, Federal programs must encourage comprehensive State programs to identify and act upon problems of maldistribution and undersupply

8. "There should be established within the Department (i.e., HEW) the function of review and approval of all Federal policies and actions that lead to or encourage new health occupations or specialities.

9. "There should be established within the Department the function of review and assessment of all Federal policies and regulations that affect the demand for or utilization of health personnel.

10. "Improvement of specific clinical competencies of health personnel is required, through advanced and short-term training and through self-instruction, particularly for the following subjects or functions:

    - long-term care of the elderly and chronically ill,
    - hospice care,
    - disease prevention and health promotion, and
    - application of new technologies.

11. "Improvement in nonclinical competencies of allied health personnel is required, through advanced and short-term training and through self-instruction, particularly in:

- teaching,
- educational program planning,
- administration and supervision, and
- performance evaluation and assessment.

12. "Maintenance and further development of allied health training centers should be encouraged so that they carry out essential interdisciplinary coordinating and planning activities.

13. "Additional allied health training centers in institutions with predominantly minority enrollments should be established.

14. "Activities for the recruitment of and assistance to minority students in allied health training programs should be increased.

15. "The MEDIHC program (Military Experience Directed Into Health Careers) to place veterans and other allied health personnel in critical vacancies, especially in small and rural institutions, should be continued.

16. "Statewide and educational system wide planing for allied health occupations education and training, through grants and cooperative agreements, should be encouraged and supported."

Coalition Recommendations for Fiscal 1982 Appropriations

Mr. Chairman, section 796 of the Public Health Service Act (Part G, Title VII) authorizes grant and contract funds which are being used for projects which focus on such issues as regional/state education coordination and management, the upgrading of credentialing systems, improved recruitment and continuing-education programs, and the development of career ladders in the Allied Health professions. The Congress has yet to authorize funding, for fiscal 1982 and subsequent years, for the continuation of initiatives made possible by the section 796 authority. House and Senate Subcommittees on Health are close to markup of their respective health-manpower bills, however, and we anticipate the inclusion of continued funding authorizations for the grant and contract authorities of section 796 in the ultimate House and Senate versions of new health-manpower law.

In addition to continuing the work already being accomplished with section 796 monies, we want to put 1982 and subsequent appropriations to work on some of the goals enumerated by the Bureau of Health Manpower. Specifically, we will want to undertake projects which focus on --

- Allied Health role delineations and related interdisciplinary curriculum modules;

- Meeting new health-service needs without creating new specialities;

- The development of mechanisms for interdisciplinary articulation;
- The use of Allied Health practitioners in containing health-care costs;
- The Allied Health related needs of unserved and underserved areas; and
- Curriculum offerings in health promotion, disease prevention and geriatrics.

Section 797 of the Act authorizes support for institutes generally designed to accomodate the "advanced" learning needs of Allied Health practitioners who, principally as a result of a rapid expansion of the Allied Health fields and increases in the numbers and varieties of Allied Health opportunities and initiatives, find themselves in new educational, supervisory or administrative settings.

Finally, section 798 of Part G, Title VII, authorizes support for a principal health-care education focus -- programs which identify, recruit, counsel, and select for entry into the Allied Health disciplines "individuals who, due to socioeconomic factors, are financially or otherwise disadvantaged to undertake education to enter the Allied Health professions...."

Only $6.7 million are authorized for the current year support of these important initiatives -- initiatives which spawn and supplement, rather than supplant state and local initiatives, and which, therefore, are consistent with the Reagan Administration's view of the federal government's role in health professions' education. Our request to you and your colleague Subcommittee members is twofold: First, that you permit no part of that $6.7 million to be rescinded; and, second, that you call for a fiscal 1982 return to the pre-recission level of $10 million.

The organizational members of the Coalition for Allied Health Professions Education greatly appreciate this opportunity to present their concerted views and your and your colleagues interest in them.

STATEMENT OF DR. RAYMOND DIBLASIO, PROGRAM DIRECTOR, AMERICAN CITIZENS CONCERNED FOR LIFE

Mr. Chairman, and members of the subcommittee, I welcome the opportunity to testify in support of maintaining the Office of Adolescent Pregnancy Programs in its present status as a separate federal entity and at its presently scheduled level of funding.

American Citizens Concerned for Life has had a long-standing interest in pregnant women, children and the family. Our overall purpose is to motivate each individual, and society as a whole, to make decisions about the use of available resources based on the premise that each human being has great value and that individuals should have the opportunity to realize their full potential. Drawing on our experience in advocacy of programs which improve the lives and meet the needs of pregnant teen-agers ACCL wishes to present for your consideration reasons why the Office of Adolescent Pregnancy Programs should neither be reduced in its funding nor included within the proposed preventive health services block grant.

ACCL was pleased to testify before the House Select Committee on Population in support of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978. In the three intervening years, we have noted a continuously increasing incidence of adolescent sexual activity, pregnancy, and childbearing. The dimensions of the needs to be met by adolescent pregnancy programs are amply documented in other testimony presented here today. As the problem grows, ACCL and organizations of similar concern look to the Office of Adolescent Pregnancy Programs for leadership in addressing the problem creatively and responsibly.

In its short life, the Office has nurtured a number of programs of promise: these are adolescent pregnancy programs which are conceptually coherent and cost-effective, and which clearly make a difference in the communities which they serve.

Mr. Chairman, in ACCL's opinion it makes good sense economically and socially to provide this promise with the opportunity for fulfillment. It makes good sense to continue the development of the initiatives undertaken by the Office of Adolescent Pregnancy Programs, to further cultivate this strong potential which has only begun to be realized.

ACCL notes with approval the administration's strong and unequivocal commitment to pro-life and family values, and its special interest in providing family-centered comprehensive care for the nation's pregnant adolescents. These values were espoused consistently throughout the presidential campaign and are being reaffirmed emphatically by administration spokespersons. We expect that this perspective will be reflected not only in federal legislation but also in the development of policies and programs at the state and local level.

In sharing the administration's enthusiasms for the value of human life and family integrity we urge that every effort be made to disseminate the benefits of adolescent pregnancy programs more broadly among all the adolescents in immediate need. It is important that the present efforts in adolescent pregnancy program development, evaluation and coordination continue unabated; it is equally important that the expertise and credibility of a federal adolescent pregnancy office be wielded in active promotion of similar efforts in every section of the country, urban and rural. The model programs which are being developed need to be emulated and adapted to special clienteles. Present and future insights concerning the phenomenon of adolescent pregnancy need to be translated imaginatively into a variety of new state and local initiatives. If the Office of Adolescent Pregnancy Programs is to realize its potential for effecting improvement in the situation of teen-agers confronting pregnancy, in addition to funding selected programs, consolidating information and coordinating other federal efforts, the Office must radiate hope and enthusiasm outwards to all those communities which have not yet taken adequate steps to address a problem which they may be reluctant to acknowledge.

If, as has been proposed, the Office of Adolescent Pregnancy Programs were to be folded into the preventive health services block grant there would be no effective way for this sort of beneficial leverage to be exerted as each state disposes of its allocation under the block grant.

There is no sufficiently organized and broadly distributed constituency capable of pressing for the interest of adolescent pregnancy programs in every stape. On the other hand, the Office of Adolescent Pregnengy Programw has already demonstrated its potential as a source of ideas and incentives to the states. Maintenance of the Office in its present status as a separate federal entity and at its presently scheduled level of funding will provide the administration with an apt channel for communicating its social vision to the states.

Mr. Chairman, ACCL believes that adolescent pregnancy is one of the most complex and urgent problems confronting contemporary society. Acting in this belief, we have been searching from the time of our founding for remedial approaches which also preserve the integrity of the family. Our concern led us to support the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978. Our interest has prompted us to hold in esteem and regard with hope the work of the Office of Adolescent Pregnancy Programs.

That same concern, interest and hope moves ACCL now to recommend that the Office be preserved in its present status and at its present appropriation level of $10 million, so that it may accomplish its vital mission to the nation.

STATEMENT OF DR. ROBERT W. BLOCK, ADOLESCENT MEDICINE, TULSA, OKLA.

The following brief comments are offered in the hope of aiding the committee in making a rational decision about continuing funds for the OAPP, and more importantly, for continuing the service-oriented funding of programs for adolescents which have been recently started throughout the country.

In a time of fiscal restraint, it seems to make sense to assign a high priority to retention of funds which are largely used for prevention of a problem, like adolescent pregnancies, which if uncontrolled results in huge expenses after-the-fact.

The most optimal decision for the current administration and congress would be to continue to support adolescent pregnancy programs for at least the remainder of the five year program planned by agencies recently receiving federal grants (1 Oct., 1980-30 Sep., 1985). A great deal of federal and local fiscal and social planning resources have been invested in the conception of newly funded programs, all of which would be wasted if funding now ceases. Also, the opportunity to see if minimal federal funding (currently less than TEN DOLLARS per pregnant teenager) can help reverse this most serious challenge to the health of children and to the well-being of the entire population.

If continuation of the status quo is rejected, then careful attention must be paid during the transition to block grants to states, that programs currently funded not be jeopardized by dilution of funds which are already only marginally adequate. Consequently, priority for funds should go to states already containing a funded program, with specific instruction that first spending should be directed at those programs.

Arbitrarily cutting welfare funds is one method of decreasing government spending. Perhaps more rational is the serious attempt to prevent increasing the number of welfare recipients. In no area can this be done more effectively, or with greater proof of cause and effect, than in the area of teenage pregnancy.

The cost/benefit ratio of government funding in the prevention of the damaging consequences to adolescent childbearing is enormously in favor of benefit. Health, of both the mother and infant, education, vocation, and other social consequences can be protected through continued efforts generated by funded programs and hopefully through greater efforts aimed at prevention of the pregnancies.

As a physician who deals daily with teenagers who are pregnant, or who are still in a position where an unwanted pregnancy can be prevented entirely, or who are young men who have questions about their responsibilities, I feel very strongly that a great disservice will be done to the youth of our country and to the adult population which shoulders the fiscal burden created by the action of youth if funding for adolescent pregnancy programs is not continued.

We cannot sit idly as the birthrate to girls less than 15 or 16 years of age increases yearly. The consequences to us all of children bearing children are now clear, and are costly. I am confident that appropriate action will be taken by the committee .

STATEMENT OF DR. DANIEL S. BLUMENTHAL, GEORGIA PUBLIC ASSISTANCE COALITION

Thank you very much for this opportunity to present testimony, on behalf of the Georgia Public Assistance Coalition, concerning the effect on children of the proposed Medicaid cap. I regret that I cannot appear in person to present the Coalition's views.

Medicaid has evolved over the past 15 years into a program of great benefit to low-income children in this country. The program's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component has been particularly important, because it has enabled hundreds of thousands of children to receive preventive medical services which they would otherwise have been unable to obtain. Perhaps the importance of preventive services in childhood is self-evident; it cannot be emphasized too strongly, however, that the prevention of disability in childhood will enable many individuals to become productive members of society rather than persons who must be supported by society.

This prevention of disability is exactly the service that the EPSDT program performs thousands of times each year. The proposed Medicaid cap will reduce the available quantity of these preventive services. This reduction will not prove cost-effective; it will, rather, result in increased costs both in terms of the treatment and rehabilitative services that will ultimately have to be provided and in terms of a loss of productive capacity in many of our citizens in years to come.

The value of EPSDT in Georgia can be readily appreciated from a brief examination of some of the program's statistics. In 1979, about 50,000 children were examined under the program; in 1980, this figure rose to about 70,000. Among the many problems discovered, approximately 20% of the children were found to have a defect in either hearing or vision. These are problems which often result in poor school performance and can prove to be a lifelong handicap if not corrected. Even if these problems were the only ones discovered in EPSDT examinations, the program would be cost-effective and worthwhile.

Medicaid has suffered through many administrative problems, but, through EPSDT, it has been one of the few programs which have proved capable of bringing comprehensive preventive services to low-income children across the country. We hope that this Congress will have the wisdom and foresight not to reduce this program.

STATEMENTS OF DR. DAVID CHADWICK, MEDICAL DIRECTOR, CHILDREN'S HOSPITAL AND HEALTH CENTER, SAN DIEGO, CALIF.

I am Dr. David Chadwick, Medical Director, Children's Hospital and Health Center, San Diego. I am also Associate Professor of Pediatrics, University of California, San Diego School of Medicine. It is in this former capacity that I submit for the hearing record this testimony regarding FY 1982 appropriations for the National Institute of Child Health and Human Development.

Children's Hospital and Health Center, San Diego (CHHC) is a 158-bed tertiary care regional pediatric center serving 2 million people in San Diego and Imperial Counties. The Institution has many special programs, including a hospital-based child protection program and one of the largest speech, hearing, and neuroscensory centers on the West Coast. CHHC also conducts a substantial amount of research in many aspects of children's health.

CHHC enthusiastically supports the research, training, prevention, education, and control programs of the National Institute of Child Health and Human Development (NICHD). In Dr. Norman Kretchmer, the Institute has a capable, energetic, and innovative leader.

NICHD conducts and supports research that focuses on the continuum of human development -- from infancy and childhood through adolescence and adulthood. As this Committee hears testimony from the various "interest groups", you should recognize that there are 45 million non-voting Americans under the age of 18 whose adult health tomorrow will depend upon the research advances that we provide support for today.

Congress has supported vital research for many years in numerous disease-categorical programs that touch upon children; the National Heart, Lung, and Blood Institute; the National Institute of Neurological and Communicative Disorders and Stroke; the National Institute of Arthritis, Diabetes, Kidney, and Digestive Diseases; and the National Cancer Institute, to name a few. But only in the NICHD is the focus of a research agency on the special health problems of women, children, and families and the means to prevent childhood conditions that result in disease, disability, and death in adult life. We share your concern, Senator Schmitt, as articulated recently in the WASHINGTON STAR, that our support for research to prevent disease must be augmented. It is beyond argument that disease or disability prevented before birth or during the early childhood years will result in life-long savings in health costs -- in terms of reduced pain and suffering, reduced lost productivity, and reduced Federal and private sector health treatment dollars.

Dr. Kretchmer testified several weeks ago before this Committee and elucidated the progress that is being made in the following NICHD research program areas: Pregnancy, Birth, and the Infant; Sudden Infant Death Syndrome; Congenital Defects; Nutrition; Child and Adolescent Development; Mental Retardation; Fertility-Infertility; Contraceptive Development and Evaluation; and Population Dynamics. It is our recommendation that Congress appropriate $249 million to the NICHD so that it may effectively maintain and modestly expand these initiatives.

Under the Administration's proposed FY 1981 rescission of $7.7 million, the NICHD would be able to support only 31% of its approved investigator-initiated research grants. More importantly, the Institute would be able to support 158 less NRSA trainees than in FY 1980.

For FY 1982, the Administration has proposed an increase of only $7.5 million over the FY 1981 continuing resolution level of $223.6 million, a meager 3% increase. Under this allocation, the NICHD would support 378 research grants, compared with 461 grants supported as recently as FY 1979. The Institute would also be forced, like all NIH Institutes, to eliminate institutional training cost allowances and phase down individual training grants support. Important contract initiatives, of the Institute's Center for Population Research, including studies of human milk, sterilization, and contraception, would be delayed or perhaps deleted from the NICHD's longer range plans. This overall biomedical research policy will further exacerbate the growing shortage of M.D.'s and Ph.D.'s entering research careers, and inhibit the transfer of basic and applied research advances "from bench to bedside".

Children's Hospital and Health Center recognizes that, in a period of economic difficulty, NIH cannot enjoy unfettered expansion. However, this Committee has always recognized that the key to prevention, the ultimate means of reducing health costs, is support for basic research and training. Our recommendation of $249 million would enable the National Institute of Child Health and Human Development to support 40% of its approved investigator-initiated research grants; to increase by 10% above FY 1981 continuing resolution levels the number of full-time equivalent NRSA trainees; and maintain current levels of contract support and intramural research.

It is our sincerest hope that this Committee will favorably consider these recommendations.

Children's Hospital and Health Center, San Diego (CHHC) is a 158-bed tertiary care regional pediatric center serving 2 million people in San Diego and Imperial Counties. The Institution has many special programs, including a hospital-based child protection program and one of the largest speech, hearing, and neuroscensory centers on the West Coast. CHHC also conducts a substantial amount of research in many aspects of children's health.

I am Dr. David Chadwick, Medical Director, Children's Hospital and Health Center, San Diego; I am also Associate Professor of Pediatrics, University of California, San Diego School of Medicine. It is in this former capacity that I submit for the hearing record this testimony regarding FY 1982 appropriations for the National Center on Child Abuse and Neglect. (The Center).

My testimony today arises from two different perspectives. First, as Medical Director of the Hospital and Head of its Child Protection Program, and as an active member of our Physical Abuse Review Committee, I come into contact with scores of abused children who pass through CHHC every year. Second, as one who has devoted a large part of my professional career to combatting child abuse, including serving as one of two consultants to the American Academy of Pediatrics on child abuse and as a frequent witness in both civil and criminal child abuse proceedings, I have come to recognize the profound impact that child abuse plays in shaping the formative years of vast numbers of America's young people. I have come to realize the important opportunities for the prevention of so many of the instances of child abuse, possibilities that begin from the very first moment of birth.

Funding of the Federal child abuse effort is of course contingent up on passage of legislation to reauthorize programs under the Child Abuse Prevention and Treatment Act of 1978. We look forward to working with the appropriate Committees in both the House and Senate to help assure passage of legislation necessary to guarantee a continued Federal presence in the field of child abuse. But for now, for you, the members of the Appropriations Committee, it is imperative that you examine from where we have come in just the last seven years.

When the Child Abuse Prevention and Treatment Act was first enacted in 1974, child abuse was an invisible problem. At the time the Act was extended and modified in 1978, we had made substantial progress in both our knowledge and our treatment of child abuse. Now, in 1981, as a direct result of Federal leadership, the subject has been moved to the forefront of the public eye.

The National Center on Child Abuse and Neglect, is to be commended for its role in providing visibility for the problem, researching the problem, and providing guidance to state and local agencies in combatting the problem.

Please allow me to highlight some of the major advances that I have seen take place due to the Center's activities.

1. Reporting. Through projects that it has funded, the Center has helped to set the mechanisms in place so that child abuse and neglect cases are reported to the appropriate law enforcement or child protection agencies in virtually all the states. Over the past four years alone, reporting has increased by more than 100 percent.

2. Interdisciplinary Cooperation. Prior to 1974, conflict among the medical and social services and law enforcement communities as to who was responsible for child abuse was pervasive. Now, this tension has all but disappeared due to the unprecedented multidisciplinary cooperation which has emanated from the interprofessional conferences, research, and demonstration projects supported by the Center. The increasing number of multidisciplinary bodies and agencies at the local and State levels can be directly attributed to the Center's effort to promote this trend.

3. Improved Services. By funding projects directed towards discovering what treatments effectively mitigate or prevent child mistreatment, and by disseminating such information, the Center has made substantial progress towards assuring that the states and localities may benefit from the most current knowledge available on effective treatments and modes of service delivery.

4. Prevention. Starting in 1978, the Center began to place high priority on prevention, by funding research assessing the effectiveness of various prevention programs. In my own practice, I have seen Center-supported research translate into a hospital-based perinatal program that has begun to provide such services as maternal outreach and perinatal education, early screening for parental problems, information and referral to community services, and paraprofessional and volunteer support and counselling. In my professional opinion, the use of funds at this earliest stage in efforts focused on prevention is the most cost-effective use of the Federal dollar. Ultimately, such a focus offers us the hope of halting child abuse before it has even begun.

5. Involvement of Other Sectors. The Center has provided the seed money for a number of groups and entities that

have continued to grow and thrive even after the Federal funds have been depleted. Over 1,000 Parents Anonymous groups have been established in every State. Family Stress Centers, such as that established in San Diego, have continued to serve families from all sectors of the community. The National Exchange Club, a benevolent fraternal organization, has recently decided to focus its primary fund-raising effort in the child abuse area. These are exactly the types of responses that will be reinforced by a continued visible Federal commitment to child abuse.

Despite this promise, despite the increase public awareness and despite the progress made, there is so much more to be done. The very success of the program to date has led us to see that abuse and neglect of children is a serious and wide-spread problem in America today. Recent studies have confirmed that each year over 1 million of children are victims of abuse and neglect. This estimate is based only on cases that have actually come to the attention of the public; most experts feel that the real incidence is two to three times higher.

Moreover, there are a number of other areas in which the tip of the iceberg has not even been touched. The problems of abuse and neglect of children in institutional settings have only recently begun to be identified. Some of the worst violations in this regard are institutions that have been funded with Federal dollars. Sexual abuse of children is another area which has only first begun to attain public attention. In FY 1980, Congress appropriated $4 million specifically for the Center to commence efforts in this area. The results of these projects -- if completed -- should provide helpful information to states and localities in developing responses to sexual abuse cases. Finally, the GAO, in a report released in April, 1980, entitled "Increased Federal Efforts Needed to Better Identify, Treat, and Prevent Child Abuse and Neglect", recommended that the Center receive additional support so that it could augment the efforts of the states to encourage people to report as required by law, improve treatment capabilities, develop prevention programs, and provide leadership and assistance to deal with child abuse and neglect. Crucially, the report recognized that Federal involvement in the child abuse area is indispensable, and that the functions it serves cannot be duplicated at the State levels.

STATEMENT OF GEORGE A. REKERS, PH. D., PROFESSOR AND HEAD, DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT, KANSAS STATE UNIVERSITY

I appreciate the opportunity to have these remarks included in the record of the hearings on the 1982 Labor - HHS - Education Appropriations bill.

My remarks address the issue of funds designated to prepare personnel involved in child welfare work. The present policy restricts these funds to schools of social work and to persons studying in schools of social work (Fed. Register, Vol. 46, No. 1, January 2, 1981, pp. 167-171 attached).

While I appreciate the contribution of social workers and schools of social work to child welfare services, I also wish to point out that the profession of family and child development has special competencies of major importance to assisting children and families. Indeed, the language and the guidelines of the recently enacted Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) speak specifically to the kinds of work with families and children that require the skills and understandings identified with family and child development education programs.

Graduate programs in family and child development involve students in the study of family dynamics and the study of ways of building family strengths. Along with the study of family processes and family consultation, the students also study both the characteristics of child and adolescent development and the processes of parent education. The focus of training in family and child development is on the developmental processes of children, the nature of family relationships and the skills of assisting families to identify and develop effective family relationships and coping strategies.

In contrast, the findings of a recent national survey of child welfare curricula in schools of social work (attachment B), conducted by staff of the University of Texas School of Social Work, suggest that the focus of training in social work schools is largely on policy and general issues and little on child and family development. While I would underscore, again, the appropriateness of legal and policy information in the preparation of social workers, I want to express also my concern that child welfare services must provide direct assistance to families in building relationships and in helping parents to provide guidance and nurture.

Federal legislation which identifies social workers as "the profession of choice" in child welfare services often erects barriers to the employment of persons with family and child development degrees. This limits the availability of developmental and educational services. For example, many families in stress could profit from educational and supportive services that help them to appropriate insights and practices from models of effective family functioning. Without family and child development workers in child welfare services, these services will not likely be available.

In his analysis of research in parent-child interaction, Dr. Davis has written, "The clear consensus emerging from an analysis of the research in child development is that the child's psychological development is profoundly and significantly influenced by the kind of care he or she received (Clarke-Stewart 1977, p. 93). Parents are worried and uncertain about how to bring up their children and increasingly seek the advice of 'experts.' In this regard Alison Clarke-Stewart (1978) estimated that 23 million parenting or child rearing primers have been bought in the past five years in the United States" (Davis, 1979).

Davis comments that parents are not alone in this quest. For example, "public policy planners are asking questions on the effects on children's development of repeated, temporary separations from mother, on what happens when fathers or other adults act as substitute caregivers, on the optimal number of caregivers for any one child, on how many children a caregiver can be expected to care for, on what kind of care supports children's development, on what qualifications, credentials, or regulations are likely to insure adequate care" (Clarke-Stewart, 1977, p. 67). The persons to whom these questions are addressed are often social workers whose training well equips them to deal with many problems facing individuals, but whose training often leaves them ill-equipped to deal with issues of normal child development, parent-child interaction and family relationships.

In summary, persons involved with child welfare services, need to have an understanding of family processes and of the characteristics of normal child development, as well as of problem situations. Because social work curricula reflects a sparseness of courses in child development and in family development, two recommendations are in order:

1) that legislation relating to child welfare services include child development and family specialists, as well as social workers, as "professionals of choice",

2) that funding for inservice and continuing professional education for social workers and other child welfare personnel include programs that provide training in child development, in family relationships and in approaches to building family strengths, such as programs of parent education.

I hope that future legislation relating to child welfare services will take these recommendations into account. Thank you for this opportunity to present this matter.

References Cited

Clarke-Stewart, A. Child care in the family: a review of research and some propositions for policy. New York: Academic Press, 1977.

Clarke-Stewart, A. Popular primers for parents. American Psychologist, 1978, 33, 359-369.

Davis, A. J. Parent-child interaction and the socialization process: a critical analysis of the research. Contemporary Education, 1979, 50, 86-92.

attachment 4

Office of Human Development Services

[Program Announcement No. 13648-813]

Administration for Children, Youth and Families; Child Welfare Services Training Grants Program

AGENCY: Administration for Children, Youth and Families, Office of Human Development Services, DHHS.

SUBJECT: Announcement of Availability of Grant Funds for the Child Welfare Services Training Grants Program.

SUMMARY: The Administration for Children, Youth and Families (ACYF) announces that applications are being accepted for *Traineeship Grants* authorized under Section 426 of the Social Security Act (part B of title IV, 42 U.S.C. 626).

DATES: Closing date for receipt of applications is March 6, 1981.

Scope of this Announcement

This Program Announcement is one of two for the Child Welfare Services Training Grants program and covers Traineeship Grants to be awarded for Fiscal Year 1981. All Traineeship Grants are awarded and administered by the regional Administration for Children, Youth and Families Program Offices.

Program Purpose

The purpose of this program is to develop the skills and qualifications of full-time students who have as their career objectives the provision of services to children and their families by providing financial support through accredited schools of social work.

Financial support is provided to Baccalaureate degree students in their senior year only, for the first or second year at the Master's of Social Work Level, and for Doctoral candidates.

Program Goals and Objectives

The goal of this program is to provide education and training opportunities for persons who are committed to entering the field of child welfare services or who are already working in the field of child welfare services, to enable them to more effectively achieve the following outcomes for children and families:

- To provide support to families in their own homes in order to prevent separation of children from their families.
- Where separation is necessary, to develop permanent plans and provide support services to enable children to be returned to their families.
- Where these options are inappropriate, to provide quality services which enable the children to become adopted or where it is the plan of choice, in exceptional circumstances, to be placed in a permanent foster home.

Applications should specify that the proposed project will achieve or is capable of achieving the following program objective:

- To enable students who have child welfare as a career objective to gain special knowledge and experience in providing services to children and their families.

Eligible Applicants

Traineeship Grants are awarded to public or nonprofit private colleges and universities offering baccalaureate or graduate degree programs in social work which are accredited by the Council on Social Work Education or have been granted candidacy status. Applications submitted by applicants not accredited or not granted candidacy status by the Council on Social Work Education will not be accepted for review.

Condition for Award

The Regional Child Welfare Training Centers are collecting data from schools of social work who have received Traineeship grants, on the employment of the recipients of Traineeships. In order to be considered for a grant award, each applicant must provide a statement that it will keep a record of the mailing addresses for a period of five years for each student who received a traineeship award. This information is to be provided annually to the Regional Training Center. For further information about this Student Tracking System the applicant should contact its Regional Child Welfare Training Center.

Available Funds

From the total appropriation of $6,000,000 available in Fiscal Year 1981, the Administration for Children, Youth and Families expects to award approxiately $1,848,094 for new traineeship grants. A new grant is the initial award made in support of a project. The project period is of one year duration. Awards are made for student costs only. In Fiscal year 1980, 136 traineeship grant applications were received for competitive review and 117 awards were made, averaging approxiamtely $27,854 each.

Additional Requirements

Traineeship grants may be awarded by institutions to students with career goals in child welfare who are enrolled in appropriate educational programs. They are available to students in their senior year at the undergraduate level, in Master's degree programs and in Doctoral degree programs. Traineeships, including stipends, tuition and educational fees, travel and dependency allowances, are available only to students enrolled full-time in degree-oriented educational programs. They may not be awarded in academic programs for less than one full academic unit of training, i.e., for a quarter, trimester, semester, or an academic year. *Traineeship appointments may not exceed 12 months without prior approval by the Administration for Children, Youth and Families.*

At the undergraduate level, the per student cost shall not exceed $1,000 for a full academic year which may be used for tuition, fees, stipend and travel expenses. At the graduate level, costs which may be covered include tuition, fees, stipend, dependency allowances and travel expenses. A table for calculating stipends and dependency allowances at the graduate level is included in the Program Guidance in the Application Kit. No other direct or indirect costs are allowable except for the following:

If a separate field placement unit is established in a state or local public welfare agency, which has an identifiable child welfare service unit, for the sole purpose of supervising trainee field placement, those costs directly attributable to the field supervision of the students will be allowable as a direct cost to the institution. An indirect cost rate not to exceed 8% of the direct costs (excluding traineeship costs) may be charged to the program (or the institution's actual indirect cost if less than 8%). The unit must consist of at least five students but not more than eight, to qualify for payment of costs for one full-time supervisor. A maximum of 7% of the total Regional Traineeship allocation may be used for field supervisory costs. Funding for this cost, however, is at the option of the Regional Office.

1. *Requirements Which Candidates Must Meet.* A candidate for a child and family service traineeship must meet the following requirements:

(a) be a citizen of the United States or a foreign national lawfully admitted to the United States for permanent residence;

(b) take the training at the educational institution designated in the traineeship award;

(c) not be an employee of the Federal Government;

(d) not currently receiving educational allowances from any other federal, state, or local public or voluntary agency when that allowance is conditional on a conflicting employment obligation incurred by the trainee, except for federally assisted student loans, or educational allowances of benefits payable under the Veterans Education and Training Amendment Act of 1977: as limited by Section 213 of said Act;

(e) be enrolled for full-time study in the grantee institution;

(f) be in the senior year if enrolled in a program leading to a baccalaureate degree;

(g) express interest in a career in the field of child and family services;

(h) indicate an expectation to return to or to seek employment in a state or local public social service agency or in another child and family service agency or facility from which the state or local agency secures services. There should be reasonable assurance of his employment in a child and family service program, public or private, upon completion of training;

(i) cooperate with the Student Tracking System on the employment of the recipients of Traineeships;

(j) meet requirements established by the grantee institution which do not negate federal requirements; and

(k) for Doctoral students, provide evidence that they have selected or will select dissertation subjects clearly related to the field of child welfare.

Grantee institutions will select the candidates to whom traineeships will be awarded on the basis of their qualifications and will document the files to reflect the eligibility of candidates. To the extent possible, the awarding of traineeships should give special attention to recruiting and selecting eligible, qualified minority candidates, and should give preference to students with limited financial resources.

2. *Stipends and Allowances.* At the undergraduate level, the total per student cost shall not exceed $1,000 for an academic year which may include stipends, tuition, fees or other costs. At the graduate level, costs which may be covered include tuition, fees, stipend, dependency allowances and travel expenses. Traineeship grants may be awarded for partial support of students at the discretion of the institution.

Dependency allowances for the dependents of graduate level students will be $600 per support year for each eligible dependent. Dependents are as defined in the Internal Revenue Code. Dependency allowances are not available to baccalaureate level trainees.

Domestic travel allowances for students from their residence to the training institution will not be provided except, in those cases of extreme need or hardship for individual students where a oneway travel allowance may be granted at the rate of up to 22.5 cents per mile. A travel allowance for reimbursement for travel to field instruction may be paid when it is the policy of the institution to pay such costs.

Grantee Share of the Project

There is no cost sharing or matching requirement for grants under this program.

The Application Process

Availability of Forms

Application for a grant under the Child Welfare Services Training Grants Program must be submitted on standard forms provided for this purpose. Application kits which include the forms, instructions and program information, including the complete Program Guidance for Fiscal Year 1981 may be obtained by writing to the "Project Officer, Child Welfare Services Training Grants" in the appropriate Regional Office listed in Appendix I.

Application Submission

One signed original and two copies of the grant application, including all attachments, must be submitted to the Regional Office address indicated in the application instructions. In order to facilitate processing of a grant application, please submit one signed original and six copies. Applications must be submitted to the appropriate Regional Office in the region in which the applicant institution is located.

The applicant must clearly identify the program announcement number for which the application is to compete. The application must be signed by an individual authorized to act for the applicant institution and to assume for the institution the obligations imposed by the terms and conditions of the grant award.

A-95 Notification Process

This program does not require the A-95 notification and review process.

Application Consideration

The Regional Program Director, Administration for Children, Youth and Families, determines the final action to be taken with respect to each grant application for this program.

Applications which are complete and conform to the requirements of this program announcement are subjected to a competitive review and evaluation by qualified persons independent of the Administration for Children, Youth and Families. The results of the review assist the Regional Program Director for Children, Youth and Families in considering competing applications. If the Regional Program Director has reached a decision to disapprove a competing grant application, the unsuccessful applicant is notified in writing. Successful applicants are notified through the issuance of a Notice of Financial Assistance Awarded which sets forth the amount of funds granted, the terms and conditions of the grant, the budget period for which support is given, and the total period for which project support is contemplated. Special consideration will be given to those applicants who have identified and selected minority students who will be awarded traineeships. In making decisions about grant awards, the Regional Program Director will take into consideration the applicant's plan to recruit minority students.

Criteria for Review and Evaluation of Traineeship Grant Applications

Completed grant applications will be reviewed and evaluated against the following criteria:

- That the project objectives are identical with or are capable of achieving the specific program objective listed in this announcement under "Program Goals and Objective".
- That proposed procedures of the work program, if well executed, will be capable of achieving the results required by the program and further defined and elaborated by the applicant, including at least the following sub-criteria:

(a) That the applicant provides assurance that it will keep a record of mailing addresses for all students who receive traineeship awards for a period of five years and that it will provide this information to the Regional Training Center annually. (This information will determine to what extent graduates enter and remain in the field of child welfare services); and

(b) That the applicant provides assurance that all student eligibility requirements specified in the Program Announcement are met.

- That the applicant describes what the institution is doing to reinforce and support the students' commitment to child welfare services, including a description of courses which students will be required to take or select from which place special emphasis on child welfare services.

- That the application includes a viable plan designed to recruit program eligible minority candidates into the traineeship program, especially those who have limited financial resources. This plan must specify activities and timetables by which the school will seek out, identify, and, when implemented, *focus* traineeship selection on minority candidates.

- That the applicant documents that it will provide a field placement program (except for Doctoral candidates) for students in which they will have an opportunity to integrate academic and field placement experiences into a more comprehensive understanding of the field of child welfare, including the following:

(a) The type of schedule the field placement follows and the number of hours a week, month, semester, etc., it entails;

(b) For each traineeship requested, specific description of and commitment in writing from an agency for a full academic year of field placement as defined by the institution, in a child welfare setting which will enable the undergraduate or Master level trainee to, (1) carry a caseload or participate in the management of a caseload primarily involving child welfare services, and, (2) work under the direction of a trained social work supervisor;

(c) A description of the policies and procedures the applicant will follow in the supervision of the students' field placement including, (1) whether there is a supervisor or director of field placement and that person's role and responsibility; (2) who provides direct supervision (the school or the field placement agency); (3) the criteria for the selection of field placements in child welfare; (4) the nature and quality of the supervisory contact sequence and, (5) the relationship between the field placement and the classroom instruction.

- That the application include one of the following two types of specific documentation that the recipients of traineeships will work in a child welfare setting upon completion of their Baccalaureate, Masters degree or Doctoral programs:

1. A letter of intent or commitment either from an institution or a public or voluntary social services agency to release employees for the pursuit of a graduate or undergraduate degree in social work. The letter of intent or commitment must specify the number of employees to be released and enrolled, described efforts made by the agencies to select minorities and employees with limited financial resources, and indicate that the person(s) released will be providing services, teaching, conducting research or administering programs in child welfare when they return to work.

2. A letter of intent or commitment from an institution or public or voluntary agency that upon completion of a degree program it will hire a trainee to provide services, to teach, conduct research, administer, or carry out programs in child welfare.

- That the applicant provides a specific list of criteria for selection of Doctoral students (if applicable) which assures that (a) they have well established interest and experience in child welfare and will work in a child welfare setting upon completion of the degree program; and, (b) they have selected or will select dissertation subjects clearly related to the field of child welfare.

- That project personnel are or will be well-qualified to provide direction and supervision to students specializing in child welfare, and the applicant organization has or will have adequate facilities and resources to conduct the project.

- That the estimated cost of the government of the project is reasonable considering the anticipated results.

Closing Date for Receipt of Applications

The closing date for receipt of applications under this Program Announcement is March 6, 1981. An application will be considered received on time if:

- The application was sent by registered or certified mail no later than March 6, 1981 as evidenced by the U.S. Postal Service postmark, or the original receipt from the U.S. Postal Service; or

- The application is received on or before close of business (COB) March 6, 1981 in the Department of Health and Human Services Regional Office mailroom. In establishing the date of receipt, consideration will be given to the time date stamps of such mailrooms or other documentary evidence of receipt maintained by the Department of Health and Human Services. *Applications received after the deadline or sent to any address other than the regional office in the region in which the applicant institution is located will not be accepted and will be returned to the applicant.*

(Catalog of Federal Domestic Assistance Program Number 13.648, Training Grants in the Field of Child Welfare)

Dated: December [illegible], 1980.

John A. Calhoun,

Commissioner for Children, Youth and Families.

Approved: December 24, 1980.

Cesar A. Perales,

Assistant Secretary for Human Development Services.

[FR Doc. [illegible] Filed 12-31-80; 8:45 am]

BILLING CODE [illegible]

Administration for Children, Youth and Families; Child Welfare Services Training Grants Program

[Program Announcement No. [illegible]]

AGENCY: Administration for Children, Youth and Families Office of Human Development Services, DHHS.

SUBJECT: Announcement of availability of grant funds for the child welfare services training grants program.

SUMMARY: *The Administration for Children, Youth and Families (ACYF) announces that applications are being accepted for Teaching Grants* authorized under Section 426 of the Social Security Act (part B of title IV, 42 U.S.C. 626).

DATES: Closing date for receipt of applications is March 6, 1981.

Scope of this Announcement

This program Announcement is one of two for the Child Welfare Services Training grants program and covers Teaching Grants to be awarded for Fiscal Year 1981. All Teaching Grants are awarded and administered by the regional Administration for Children, Youth and Families Program Offices.

Program Purpose

The purpose of this program is to develop, expand, and improve educational programs and resources for preparing students for work in the field of child welfare.

Program Goals and Objectives

The goal of this program is to provide education and training opportunities for persons who are committed to entering the field of child welfare services, or who are already working in the field of child welfare services, to enable them to more effectively achieve the following outcomes for children and families:

- To provide support to families in their own homes in order to prevent separation of children from their families.

- Where separation is necessary, to develop permanent plans and provide support services to enable children to be returned to their families.

- Where these options are inappropriate, to provide quality services which enable the children to become adopted or where it is the plan of choice in exceptional circumstances to be placed in a permanent foster home.

Applications for projects should specify that the proposed project will achieve or is capable of achieving one of the following specific program objectives:

- To develop degree oriented curricula organized into specific course sequences for use by the applicant school of social work, which (1) address issues and problems in the practice of child welfare in an organized and comprehensive manner and (2) integrate a child welfare field placement program which supports a comprehensive learning experience for students entering a child welfare specialization; or

- To develop curricula which address child welfare issues in an organized, comprehensive and practice relevant manner for a school of continuing education which is part of or affiliated with the applicant school of social work.

Eligible Applicants

Teaching grants are awarded to public or nonprofit private colleges and universities offering baccalaureate or graduate degree programs in social work which are accredited or granted candidacy status by the Council on Social Work Education. Applications submitted by applicants not accredited or not granted candidacy status by the Council on Social Work Education, will not be accepted for review.

Available Funds

Of the total appropriation of $5,800,000 available in Fiscal Year 1981, the Administration for Children, Youth and Families expects to award approximately $1,848,094 for new teaching grants. A new grant is the initial award made in support of a project. The project period is of one year duration. An indirect cost of 8% of the direct costs (or the institution's actual indirect cost if less than 8%) is allowable for this grant program. In Fiscal Year 1980, 138 teaching grant applications were received for competitive review and 81 awards were made, averaging approximately $28,167 each.

Grantee Share of the Project

There is no cost sharing or matching requirement for grants under this program.

The Application Process

Availability of Forms

Application for a grant under the Child Welfare Training Grants Program must be submitted on standard forms provided for this purpose. Application kits which include the forms, instructions and program information, including the complete Program Guidance for Fiscal Year 1981 may be obtained by writing to the "Project Officer, Child Welfare Services Training Grants" in the appropriate regional office listed in Appendix I.

Application Submission

One signed original and two copies of the grant application, including all attachments, must be submitted to the Regional Office address indicated in the application instructions. In order to facilitate processing of a grant application, please submit one signed original and six copies. Applications must be submitted to the Regional Office in the region in which the applicant institution is located. *The applicant must clearly identify the program announcement for which the application is to compete.* The application must be signed by an individual authorized to act for the applicant institution and to assume for the institution the obligations imposed by the terms and conditions of the grant award.

A–95 Notification Process

This program does not require the A-95 notification process.

Application Consideration

The Regional Program Director, Administration for Children, Youth and Families, determines the final action to be taken with respect to each grant application for this program. Applications which are complete and conform to the requirements of this program announcement are subjected to a competitive review and evaluation by qualified persons independent of the Administration for Children, Youth and Families. The results of the review assist the Regional Program Director, Administration for Children, Youth and Families, in considering competing applications. If the Regional Program Director has reached a decision to disapprove a competing grant application, the unsuccessful applicant is notified in writing. Successful applicants are notified through the issuance of a Notice of Financial Assistance Awarded which sets forth the amount of funds granted, the terms and conditions of the grant, the budget period for which support is given, and the total period for which project support is contemplated.

Criteria for Review and Evaluation of Teaching Grant Applications

Completed grant applications will be reviewed and evaluated against the following criteria:

- That the project objectives are identical with or are capable of achieving one of the specific program objectives listed in this announcement under "Program Goals and Objectives".
- That proposed procedures of the work program, if well executed, will be capable of achieving the desired results, including (1) the plan for accomplishing the purpose(s) and objectives, (2) timetables for their accomplishment, and (3) information about the number and type of students to be directly affected by the teaching grant.
- That the project personnel are or will be qualified to develop child welfare curricula and the applicant organization has or will have adequate facilities and resources to conduct the project.
- That the applicant describe consultations held in planning the project with state and/or local public social service agencies and other interested agencies and groups.
- That the applicant (1) describes what child welfare issues will be covered in an organized and comprehensive manner; and (2) where applicable, describes how its child welfare field placement program will support a total comprehensive learning experience for students entering a child welfare specialization.
- That the applicant has a clear plan for establishing an advisory group made-up of persons providing child welfare services, including both the public and voluntary sector, and that this advisory group will meet regularly to provide practice relevant technical assistance in the course design and will review various draft materials, including the final product.
- That the applicant describes specific plans to implement the curricula into the ongoing program of the school of social work or school of continuing education, including projected information about the qualifications of the person(s) who will teach the course(s), how often they will be offered, and what students will be eligible to take the course(s).
- That the applicant describe what resulted from past Teaching Grants (if applicable);
- That the applicant describe how this effort is new or an expansion or improvement of past Teaching Grants (if applicable);

- That the applicant describe what new, expanded or improved resources or products will be developed as a result of this grant which can be replicated for use by other schools. (The grantee must ensure that the work of this grant is not a duplication or repetition of past grants.)
- That the estimated cost to the government and the project is reasonable considering the anticipated result, and that the applicant has included funds to send at least one key person to a statewide or regional meeting on child welfare curriculum issues.

Closing Date for Receipt of Applications

The closing date for receipt of applications under this Program Announcement is March 6, 1981. An application will be considered received on time if:

- The application was sent by registered or certified mail not later than March 6, 1981 as evidenced by the U.S. Postal Service postmark, or the original receipt from the U.S. Postal Service; or
- The application is received on or before close of business (COB) March 6, 1981 in the Department of Health and Human Services Regional Office mailroom. In establishing the date of receipt, consideration will be given to the time date stamp of such mailrooms or the documentary evidence of receipt maintained by the Department of Health and Human Services.

Applications received after the deadline or sent to any address other than the regional office in the region in which the applicant institution is located will not be accepted and will be returned to the applicant.

(Catalog of Federal Domestic Assistance Program Number 13.608, Training Grants in the Field of Child Welfare)

Dated: December 9, 1980.

John A. Calhoun,

Commissioner for Children, Youth and Families.

Approved: December 20, 1980.

Cesar A. Perales,

Assistant Secretary for Human Development Services.

[FR Doc. 80-[illegible] Filed 12-31-80; 8:45 am]

BILLING CODE 4110-92-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

Baker District Advisory Council; Meeting Correction

This correction is made to change the Meeting Notice published in Federal Register on December 12, 1980 from January 2, 1981 to January 21, 1981.

Gordon R. Staker,

District Manager.

December 22, 1980.

[FR Doc. 80-40664 Filed 12-31-80; 8:45 am]

BILLING CODE 4310-84-M

New Mexico; Albuquerque District, New Mexico; District Advisory Council Meeting

The Albuquerque District Advisory Council will meet January 21, 1981, at the Albuquerque Convention Center, San Juan Room, starting at 10 a.m.

This council is managed in accordance with the Federal Advisory Committee Act of 1972, the Federal Land Policy and Management Act of 1976 and the Public Rangelands Improvement Act of 1978.

The public is welcome to attend all portions of this meeting. Statements by the public may be made to the Council at 3 p.m. A time limit may be imposed for each statement depending on the number of people wishing to speak to the Council.

This is the third meeting of of the Albuquerque District Advisory Council and is being held one day prior to the San Juan River Regional Coal Team meeting, January 22, at the Sheraton Old Town Inn, Albuquerque, to facilitate comment by the Council to the Regional Coal Team.

The agenda will include: procedural questions as to the functioning of the Council; a presentation by BLM on District rangeland improvement programs; discussion of the Chaco/San Juan Unit Resource Analysis for the planning update for coal and possible preparation of statements of interest in, or concerns about, federal coal development to be addressed to the Regional Coal Team the following day.

Minutes of the meeting will be prepared and made available for review within 30 days following the meeting (February 20, 1981).

Mathew Millenbach,

Acting District Manager.

December 17, 1980.

[FR Doc. 80-[illegible] Filed 12-31-80; 8:45 am]

BILLING CODE [illegible]

[W-73370]

Wyoming; Proposed Withdrawal and Reservation of Lands

December 18, 1980.

By virtue of the authority contained in Section 204 of the Act of October 21, 1976 (43 U.S.C. 1714), the Bureau of Land Management proposes to withdraw the following described lands from location and entry under the general mining laws (30 U.S.C. Ch. 2), subject to valid existing rights:

Sixth Principal Meridian, Wyoming

T. 15 N., R. 82 W.,
  Sec. 14, NE¼, N½NW¼, N½SE¼NW¼, N½NW¼SE¼, SE¼NW¼SE¼, and NE¼SE¼;
  Sec. 15, NW¼SW¼NE¼, S½SW¼NE¼, SE¼NW¼, SE¼SW¼NW¼, SW¼, W½SE¼, and W½E½SE¼;
  Sec. 23, S½S½NE¼, S½SE¼NW¼, NE¼SW¼, S½SW¼, and N½SE¼;
  Sec. 26, N½, N½S½, S½SW¼, and SW¼SE¼.

The area described contains 1,550.00 acres of public lands located within the Bureau of Land Management's Bennett Peak Recreation Area in Carbon County, Wyoming.

The purpose of this withdrawal is to afford the above-described lands the same protection presently assigned to the other public lands within the Bennett Peak Recreation Area to insure protection of wildlife habitat and outdoor recreation values.

On or before February 2, 1981, all persons who wish to submit comments, suggestions, or objections in connection with the proposed withdrawal may present their views in writing to the undersigned officer of the Bureau of Land Management.

Pursuant to Section 204(h) of the Federal Land Policy and Management Act of 1976, notice is hereby given that an opportunity for a public hearing in connection with the withdrawal is afforded. All interested persons who desire to be heard on the proposed withdrawal must submit a written request for a hearing to the State Director, Bureau of Land Management, at the address shown below by February 2, 1981. Upon determination by the State Director that a public hearing will be held, the time and place will be announced.

The Department of the Interior's regulations provide that the authorized officer of the Bureau of Land Management will undertake such investigations as are necessary to: (1) determine the existing and potential demands for the lands and their resources; and (2) to provide for the maximum utilization of the lands.

The authorized officer will also prepare a report for consideration by the Secretary of the Interior who will determine whether or not the lands will be withdrawn as requested. The determination of the Secretary on the application will be published in the Federal Register. A separate notice will be sent to each interested party of record.

Child Welfare Curricula in Schools of Social Work: A National Survey

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A nationwide survey of courses in child welfare in undergraduate and graduate programs indicated little movement toward any radical change in the current setup.

From the middle 1960s to the early 1970s the professional literature reflected a lively interest in the nature and scope of child welfare instruction in social work education. Some articles focused on general training for the large number of skilled individuals expected to be needed as a result of the rapid expansion of children's and other social programs [2;3;7;8;10;11;14]. Later articles detailed instructional programs in more specific areas such as field instruction, substitute care, etc. [1;9;12]. More recently, however, little information on social work education in child welfare has appeared. The profession is left with no current information on the nature of child welfare instruction in schools of social work. It is not clear whether child welfare still is considered a discrete part of social work education in either general or specific terms. This study reports on a recent empirical survey to determine the character of instruction in child

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welfare in schools of social welfare throughout the country. It describes existing curricula and identifies emerging trends that may shed light on current and future directions of education in the area of child welfare and in the social work profession in general.

Methodology

Instruments and Procedure

The instruments for data collection were two questionnaires developed especially for the study.* The first served as a cover letter explaining the research project and as a device to determine whether the school had an undergraduate and/or graduate curriculum and whether child welfare instruction was offered. Names of the instructors were requested if the institution offered courses in child welfare.

The second questionnaire was mailed directly to the instructors whose names were furnished. It asked for information on the titles of child welfare courses they taught, of other such courses offered at the school and of suggested courses not offered but desired. Traditional child welfare content areas were listed, and instructors' opinions of their students' knowledge in each area were sought. Additionally, instructors were asked to indicate percentages of actual time devoted to the content areas, versus what the ideal time percentages might be. Finally, each instructor was asked to list the three knowledge areas and three skill areas primarily taught currently, and three areas in each category not taught but desired.

Sample

The questionnaires were mailed in May 1978, to either the dean, director or chairperson of all of the undergraduate and graduate social work programs in the United States and Puerto Rico accredited at the time by the Council on Social Work Education [5]. One copy of the first survey/cover letter and two copies of the second questionnaire were included in this mailing. As many as five followups were sent to schools not responding to the initial mailing. By the end of the summer, when followups ceased, the first questionnaire had been completed and returned by 231 schools, a response rate of 96%.

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*For a copy of the questionnaires and the complete results of the study, write Michael L. Lauderdale, School of Social Work, University of Texas at Austin, Austin, TX 78712.

Of the second questionnaire sent to each school in the first mailing, 87 were returned by individual instructors. No more of these instruments were sent until all the followups of the first questionnaire were completed. Then further copies of the second questionnaire were mailed to each instructor whose name had been furnished by schools at which child welfare was part of the curriculum. By October 1979, 35 additional second questionnaires were completed and returned, yielding a total sample of 122 instructors, a response rate of 68%.

Findings

School Content

The first questionnaire yielded data on the distribution of child welfare instruction among undergraduate and graduate programs. Among the 231 social work schools responding, 142 (62%) offered only an undergraduate program, 30 (13%) reported offering only a graduate program, and 59 (26%) reported having both undergraduate and graduate programs. In all, there were 201 undergraduate programs and 89 graduate degree programs.

Among graduate schools, 70 (79%) reported offering at least one course related to child welfare. Of the undergraduate schools, 96 (47.8%) included child welfare in their curriculum. Thus, child welfare instruction appeared more likely to be offered in graduate programs than undergraduate programs. The programs that included child welfare in their course schedules tended to have more than one instructor in the subject (mean = 1.7), and a few had as many as five.

Instructor Content

Of the 122 instructors responding to the second questionnaire, 75 (62%) were female. The mean age of the total sample was 43.5 years. Faculty ranks were distributed as follows: professors, 16%; associate professors, 16%; assistant professors, 43%; instructors, 16%; and other various designations, 9%. In terms of educational background, the largest number of respondents, 70%, had social work master's degrees, 28% had doctorates (18 Ph.D., 12 D.S.W., and four other), and 2% had bachelor's level training.

The mean level of general undergraduate teaching experience was 4.5 years (SD = 4.5 years), and the mean number of years of graduate teaching experience was 5.0 (SD = 7.4). With respect to teaching experience specifically in child welfare, the mean years of undergraduate instruction were 2.6 (SD = 2.9), and of graduate instruction were 2.7 (SD = 5.3).

Course Titles

No attempt was made in either questionnaire to define child welfare operationally. It was expected that course titles and knowlege and skill areas mentioned by instructors would serve to suggest at least an academic definition. Because of the quantity and variety of these responses, some categorization was required. The categories used, however, were derived solely from the instructors' reports. No attempt was made to structure categories on the basis of existing conceptualizations. It was hoped that having respondents list areas they taught, as well as those they would like to teach, would help to formulate a definition and to identify potential trends.

Instructors were asked to list titles of up to five courses related to child welfare currently taught at their schools, and up to two course titles not taught but desired. On the basis of the content suggested by the titles, the responses were grouped into 16 categories. Among undergraduate responses the category of "General Child Welfare" accounted for 42% (79 of 188) of the course titles reported. Only three other categories accounted for more than 5% of the total: "Childhood" (including developmental and related titles), 9%; "Family Issues," 6%; and "Abuse and Neglect," 5%. A "Miscellaneous" category accounted for 7% of the course titles, and most of the rest were divided among such categories as "Adolescence," "Substitute Care," "Policy Issues," and "Casework and Treatment." Among undergraduate course titles not taught but desired, "General Child Welfare" was again the most frequently mentioned category, with 15% (eight of 55) of the responses. It was closely followed by "Substitute Care" (13%), "Abuse and Neglect" (11%), and "Legal Issues, Rights and Advocacy" (11%). "Policy Issues," "Practice Issues" and "Protective Services," all with 9%, were also strong categories.

Graduate course titles were more dispersed across the various categories. "General Child Welfare" was most frequently mentioned among categories of course titles being taught. It was a much smaller proportion than among undergraduate course titles, though. Close behind it were "Family Issues" (12%), "Miscellaneous" (11%), "Legal Issues, Rights and Advocacy" (9%), and "Policy Issues" (9%). "Substitute Care" (8%) and "Casework and Treatment" (8%) were also important. Among graduate course titles not taught but desired, the category of "Special Problems with Children" was mentioned most often, with 22% (seven of 31) of the responses. Just behind it with 19% was the category of "Family Issues," followed by "General Child Welfare" (10%), "Legal Issues, Rights and Advocacy" (10%) and "Protective Services" (10%).

Knowledge and Skill Areas

Respondents were asked to list up to three each of the knowledge areas taught, and not taught but desired, and skill areas taught, and not taught but desired. Knowledge area responses were grouped into 15 categories. Of those taught on the undergraduate level the most frequently mentioned category was "Substitute Care," with 18% (47 of 265) of the responses. It was followed by "Services Systems" (14%), "General Child Welfare" (14%), "Miscellaneous" (11%), and "Legal and Legislative Issues" (8%). Among undergraduate knowledge areas not taught but desired, areas in the "Miscellaneous" category accounted for 26% (34 of 129) of the responses, indicating a great diversity of desired areas. Among identifiable desired areas the "Legal and Legislative Issues" category accounted for 18% of the responses, followed by "Administrative Issues" (11%) and "Policy Issues" (10%).

The most frequently mentioned knowledge areas taught on the graduate level fell into the category of "Substitute Care," with 15% (16 of 105) of the responses. Other important categories were "Legal and Legislative Issues" (12%), "Service Systems" (11%), "Miscellaneous" (11%), "Administrative Issues" (10%), and "Policy Issues" (9%). As opposed to its tie-for-second rating among the undergraduate knowledge areas taught, the "General Child Welfare" category accounted for less than 6% of the graduate responses. Among graduate knowledge areas not taught but desired, the "Miscellaneous" category, as it had for undergraduate desired areas, accounted for the most responses (21%, or 12 of 57). Other important desired area categories were "Substitute Care" (12%), "Administrative Issues" (11%), "Legal and Legislative Issues" (11%), and "Childhood" (9%).

Skill areas listed by the respondents were divided into 13 categories. Because of the wide variety of skills mentioned, the "Miscellaneous" category accounted for the greatest number of responses (22%, or 92 of 416 responses) across both undergraduate and graduate areas taught and desired. The results detailed in the following include only the 12 remaining nonmiscellaneous skill area categories.

On the undergraduate level the category of skill areas most frequently taught was "Treatment Skills," accounting for 28% (52 of 184) of all responses. The other categories that accounted for a noteworthy proportion of the responses were "Assessment/Diagnosis" (12%), "Substitute Care Skills" (8%), and "Skills with Parents" (8%). "Treatment Skills" was also most frequently mentioned among undergraduate skill areas not taught but desired (13%, or 15 of 113 responses). "Administrative Skills" (11%) and "Skills with Children" (10%) were other important categories of desired undergraduate courses in skill areas.

Among graduate areas actually taught, "Treatment Skills" predominated, with 18% (13 of 73) of the responses. Also frequently taught were "Skills with Parents" (14%), "Administrative Skills" (11%), and "Skills with Children" (8%). Of graduate level skill areas not taught but desired, the most frequently reported fell in the category of "Skills with Parents" (15%, or seven of 46). The other important categories of desired areas were "Administrative Skills" (13%), "Skills with Children (13%), and "Treatment Skills" (13%). It should be noted that the "Skills with Parents" and "Skills with Children" categories may be seen as more specific but thematically identical to the "Treatment Skills" category, and so skills related to treatment in general may be seen to hold great importance as an area of instruction.

Actual and Ideal Course Content

A list of 16 content areas common to child welfare was included in the second questionnaire, and instructors were asked to estimate the percentage of overall time actually spent on each in the courses they taught and the ideal percentage they would like to spend on each. The figures reported were then averaged to obtain a mean percentage for actual and ideal time in each content area.

Among undergraduate instructors ($N = 64$) the area of "Protective Services" was reported to have the highest mean percentage of time for both actual and ideal (14% and 14%, respectively). Other content areas with high actual and ideal mean percentages were "Foster Family Care" (8% and 9%), "Supportive Services" (8% and 8%), and "Adoption" (7% and 7%). Content areas with the lowest mean percentages were "Status Offenders" (3% and 3%), and "Licensing" (2% and 3%).

Graduate instructors (N = 21) reported the highest actual and ideal percentage of time devoted to the area of "Policy" (mean percentages equal 10% and 11%, respectively). The "Protective Services" area was a close second with mean percentages of 10% and 10%. Other areas with comparatively high percentages were "Legislation" (7% and 8%), "Supportive Services" (6% and 8%), and "Federal-State Roles" (7% and 6%). "Homemaker Services" (3% and 3%) and "Licensing" (2% and 2%) were reported as having the smallest actual and ideal percentages of graduate instruction time.

In reviewing the percentages, it is apparent that protective services were both actually and ideally important on each academic level, though slightly more so among undergraduate than graduate courses. Undergraduate courses emphasized instruction in substitute care and supportive services to a slightly greater extent than other areas, whereas "Policy" was a leader in graduate course content. No other content areas stood out on either academic level, and there appeared to be no content area that overwhelmingly characterized undergraduate or graduate instruction.

Also important in reviewing actual and ideal content-area time percentages is the degree to which the two match, or the directions in which they diverge. Differences between the mean percentages for each content area ranged between 0.9% and 0.1% on the undergraduate level, and between 1.3% and 0.2% on the graduate level. The ideal percentages were higher in 12 of 16 content areas on both the undergraduate and graduate levels, indicating that any difference in instruction from its present state would be in the direction of more time devoted to most areas.

Evidence suggested, however, that no major desire existed among instructors to change the present distribution of instruction time. The basis for this was the strength of the relationship between actual and ideal content-area time percentages as measured by a Pearson's r computed for each content area and for both academic levels. These coefficients showed meaningful positive relationships between actual and ideal percentages across all content areas. The coefficients for the undergraduate percentages ranged between .55 and .93, with an overall r of .78; all were significant at below the .001 level of probability (H_0: $r = 0$). For the graduate percentages, the correlations between actual and ideal ranged between .45 and .98, with an overall r of .76. All these coefficients were significant at below the .05 level of probability.

Student Knowledge of Course Content

In the second questionnaire instructors were asked to rate the students' knowledge in each content area on a seven-point Likert-type scale. A "1" on the scale represented "very little knowledge," and a "7" represented "very much knowledge." Means were computed for each content area and academic level.

Undergraduate child welfare students were perceived by their instructors to have the highest level of knowlege in the area of "Protective Services," with a mean rating of 5.2. The next highest ratings were for knowledge of "AFDC Services" (*M* = 4.6), "Supportive Services" (*M* = 4.5), and "Adoption" (*M* = 4.5), all appreciably lower than the rating for "Protective Services" knowledge and only slightly higher than the midpoint of 4. The lowest undergraduate knowledge rating was in "Licensing" (*M* = 2.9), followed by "Funding Sources" (*M* = 3.2). The overall mean knowledge rating for undergraduates was 4.1.

Graduate students were rated highest by their instructors in their knowledge of the "Policy" area (*M* = 5.0). Like undergraduates, they were also rated comparatively high in knowledge of "Protective Services" (*M* = 4.9), followed by "Supportive Services" (*M* = 4.5) and "Legislation" (*M* = 4.5). Graduate students' lowest ratings were in "Licensing" (*M* = 3.0) and "Homemaker Services" (*M* = 3.1). The overall mean of perceived graduate student knowledge was 4.0.

The low rating of undergraduate and graduate students' knowledge of "Licensing" agrees with earlier data showing "Licensing" to be the content area with the lowest proportion of course time devoted to it. In the same vein, undergraduate knowledge ratings were highest in the area of "Protective Services," and graduate student ratings were highest in "Policy." Each area was allotted the highest proportion of course time, respectively, as reported in the section on actual and ideal course content. Means of knowledge ratings in the other content areas were fairly evenly distributed between these two extremes, and ratings for undergraduate levels seemed to vary similarly from one content area to the next. The standard deviations for each area indicated no major differences in variability of ratings between content areas. Across all areas, neither undergraduate nor graduate student knowledge was rated significantly higher than the other.

Summary and Discussion

The results of this study shed light directly on the nature of current education in the area of child welfare, and may indirectly illuminate some aspects of social work education in general. To address the latter issue first, there are many works in the recent literature that characterize social work education as a continuum from the general to the specific [4;6;13;15]. In this view undergraduate social work education is concerned with broad topics of social work interest designed to acquaint the student with the nature of the field as a whole. Graduate education is seen as the forum for closer and more practice-oriented exploration of specialty areas within the field, of which child welfare is an example. Some of the findings of this study support that view. For instance, the initial survey instrument found a much higher proportion of graduate schools teaching child welfare courses than undergraduate schools. This may be indicative of undergraduate programs' perceived position at the more general end of the continuum, concerned with more global social work topics. Specialty-area training such as child welfare can be expected to be more widespread on the graduate level.

Further evidence is found in terms of the differences between existing child welfare curricula on the two levels. Divisions between undergraduate and graduate percentages among the categories of course titles, knowledge areas and skill areas are discernibly in the direction of more practice orientation on the graduate side. Graduate course titles, for example, are much more widely dispersed among the various categories than are the undergraduate titles. Similar trends are seen in the distribution of instruction in knowledge areas and skill areas. Undergraduate instruction is concentrated in a few categories, whereas graduate instruction is dispersed among various categories.

With respect to the portrait of current child welfare instruction suggested by the results, an important factor is the strong relationship demonstrated between what instructors now teach and what they would like to teach. In each content area, the ideal and actual categories are significantly and meaningfully correlated. This does not indicate a likelihood of immediate change in existing patterns of content. There is no indication that instructors wish to alter the way they now approach child welfare instruction.

On the undergraduate level, "General Child Welfare," "Substitute Care," and "Legal Issues" predominate among course titles and knowledge areas. Course titles involving "Family Issues" are frequently taught, and more are desired. This category is not among the most important knowledge areas or skill areas, however. "Policy" appears to be a strong component of graduate education, and more instruction in the category is desired on the undergraduate level. Skills related to treatment vastly predominate among those both taught and desired, and there is no indication of impending change in this emphasis.

Instructors tended to rate their students' overall knowledge in child welfare at almost the center of the scale for both undergraduate and graduate students. In view of the evidence that instructors are currently teaching close to their ideal contents, we are led to assume that the respondents are satisfied with present levels and areas of student knowledge. Or perhaps such findings simply represent instructor awareness that, even on the graduate level, only a certain amount of knowledge in a particular content area may be imparted through academics. The rest is left for the student to acquire in practice settings.

The results of this study are more useful in indicating what is than in suggesting what may be coming about in child welfare instruction. The "what is" does not appear to differ radically from what might have been expected. That is, "Substitute Care," "Policy," "Legal Issues," and other general areas still comprise the bulk of course content. It is likely, in view of the history of both social work education in general and child welfare instruction in particular, that the "what may come about" will be the result of demands from field settings rather than from forces arising from educational trends.

Implications for further study are seen in a couple of important areas. First, it is noteworthy, in view of the importance of field education (practica, internships, etc.) in current social work education dialogue, that almost no mention of this method of instruction was made by the instructors. More information is needed to determine if this finding is representative of a general dearth of field instruction in child welfare, or if it is merely an artifact of this particular study. Also, to poll instructors on the nature of education offers only one perspective of the area. A comprehensive picture of a practice field requires input from its practitioners. With respect to the lack of directionality in the findings mentioned earlier, such input would help to fill the gap. Information from those who employ graduates of the current programs, for instance, would offer valuable assistance in sharpening the relevance of professional education in child welfare. ◆

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STATEMENT OF CHILD WELFARE LEAGUE OF AMERICA

The Child Welfare League of America appreciates the opportunity to submit for the hearing record comments on Title VI of the Health Services and Centers Amendments of 1978, the Adolescent Health Services and Pregnancy Prevention and Care Act; and Title X of the Public Health Service Act, the Family Planning and Population Research Act.

The Child Welfare League of America was established in 1920 and is the only national voluntary membership and standard setting organization for child welfare agencies in the United States. Our agencies provide adoption, day care, day treatment, foster care, institutional care, maternity home care, protective services, residential treatment, runaway and shelter care, and services to unmarried parents. The League is a privately supported organization devoting its efforts completely to the improvement of care and services for children. There are nearly 400 child welfare agencies affiliated with the League, including representatives from all religious groups as well as non-sectarian public and private non-profit agencies. In addition 1600 child care agencies are represented through membership in State Child Care Associations affiliated with the Office of Regional, Provincial and State Child Care Associations, a division of the League.

Our particular interest in Title VI and Title X relates to direct services our agencies provide. Over 200 of the Child Welfare League member agencies serve pregnant adolescents and adolescent parents, many provide maternity care, and the Florence Crittendon Division of the League represents agencies with over 100 years of service to young, pregnant women. Future funding of these two programs is of particular concern to the clients we serve.

TITLE VI -- ADOLESCENT HEALTH SERVICES AND PREGNANCY PREVENTION AND CARE ACT

This legislation was passed in 1978 to fill a void in services to pregnant adolescents and adolescent parents. While preventive family planning services reach half of the 5 million sexually active teenage girls, approximately one million become pregnant each year. For the 600,000 who choose to continue their pregnancies, comprehensive support services are limited in local communities. Most communities offer health services, but young mothers have multi-service needs which existing programs do not meet.

P.L. 96-626, the Adolescent Health Services and Pregnancy Prevention and Care Act, established a grant program to provide funds for comprehensive services to pregnant adolescents and adolescent parents, with particular concern for adolescents 15 years of age and younger. A grantee must provide specific services either directly or through referral. The legislation requires shared responsibility for funding between the federal government and the community and requires projects to demonstrate self-sufficiency after federal money is discontinued. Without the resources, and leverage of federal participation through Title VI, economic pressures will force many communities to reduce their commitment to this young population.

During the past year, the Research Department of the Child Welfare League of America has directed a study of young mothers. The findings of this study support our position that there is a direct correlation between the availability of services to pregnant adolescents and the ability of pregnant adolescents and adolescent parents to become self-sufficient members of society. Of the 182 mothers, 15 years of age or younger, interviewed, 87 percent attended special school programs for pregnant adolescents. These programs keep them in touch with other services -- counseling, health, and social services programs. School attendance before birth encouraged continuity in attendance after birth: 84 percent were still in school when their babies were three to four months old. The majority of these young mothers, ideally, want to stay in school, find employment, and have one or two children. Realistically, they are not certain whether they will be able to complete high school because of the lack of on-going support services they need to cope with their new responsibilities.

Encouraging young mothers to stay in school and providing the services necessary to accomplish this is critical to the future of these young parents. A study by the Urban Institute showed that women who achieve at least a high school education are only half as likely to live in a household receiving Aid to Families with Dependent Children(AFDC).[1] And in no study of early parenthood have even half of the women who became mothers at 17 or younger managed to acquire twelve years of education.[2] Early pregnancy jeopardizes school completion, increases the likelihood of unplanned subsequent pregnancies, and proscribes a future of dependency for many young mothers. A small response and hope for some of these young women to achieve independence is the Title VI program.

The initial appropriation for this program was $1 million in 1979. With this money, four projects were funded: Florence Crittendon Services of Houston, Texas ($93,683); Addison County Parent and Child Center, Middlebury, Vermont ($135,910); Southwest Bronx Youth Service Project, New York City ($398,770); and Family Planning Services of Central Massachusetts, Worcester, Massachusetts ($11,637). With the federal money Florence Crittendon Services of Houston, a Child Welfare League agency, was able to expand services through outreach programs in the schools, improve services to the families of pregnant adolescents, and develop a two year follow up program for young (14 years of age and younger), high risk adolescents.

In 1980 the program received a $7.5 million appropriation and awarded 23 grants (see attached). In addition, funding continued for the four original projects. The 27 projects funded by the Office of Adolescent Pregnancy Programs represent a diversity of approaches to service delivery: school-based, social service-based, medical-based; single-site and coordinated programs; rural and urban settings. The documentation and evaluation required of these grantees will begin to build an understanding of effective social services delivery to this population.

The Title VI program has been mentioned for inclusion in the preventive health services block grant proposal. The irony of that recommendation is that the reason the Adolescent Pregnancy program was initially introduced was that the two related block grants -- Title XX, the social service program, and Title V, the maternal and child health program -- were not addressing the needs of this young population. In theory, either of these other programs could provide services. In fact neither program provided the comprehensive services needed. There will be even less chance that this will happen in the proposed preventive health service block grant.

The proposed preventive health service block grant would include such programs as family planning services, the high blood pressure program, the hemophilia program, genetic services and lead-based paint poisoning prevention. The appropriation for the aggregate of these programs would be reduced by at least 25 percent. Competition for funds will be highly politicized. The constituency for pregnant adolescents and adolescent pregnancy programs is not well-organized, especially since the program is only two years old. The potential impact of the consolidation proposal is to jeopardize funding of the 27 programs which have received initial grants from the Office of Adolescent Pregnancy Programs or completely eliminate services to pregnant adolescents in local communities.

We recommend that a targeted program for pregnant adolescents and adolescent parents be maintained. We recommend an FY 1982 appropriation of not less than $10 million to permit continuation of this young and promising program.

TITLE X OF THE PUBLIC HEALTH SERVICE ACT -- FAMILY PLANNING AND POPULATION RESEARCH

Another program targeted for consolidation in the preventive health service block grant is Title X of the Public Health Service Act -- the Family Planning and Population Research program. Since it is unclear in any of the preliminary administration proposals what is happening to the population research component of this program, we will primarily address the family planning service program. However, we wish to go on record in support of a strong federal commitment to population research. A recent study by one of our Child Welfare League agencies showed that subsequent, unplanned pregnancies to adolescent mothers in their program occurred primarily because existing methods of birth control are inadequate. Contraceptive development is one important aspect of the population research program and one that needs continued support.

The Title X family planning program is a ten-year-old program with a proven record of cost-effectiveness and success. The program provides family planning services to four million women annually, including 1 million adolescents. The appropriation for Title X has increased in 10 years from $6 million to $166 million, demonstrating Congressional commitment to the effectiveness of the program.

Accomplishments of the Title X program include:

-- A scientifically documented savings for the government of $1.80 for every $1.00 invested in family planning the preceding year;

-- A marked increase in the use of the most effective contraceptive methods over the last decade;

-- A doubling of the proportion of unmarried teenagers using the most effective methods between 1971 and 1976; and

-- The prevention of an estimated 1.4 million unwanted births as a direct result of the program between 1971 and 1976.

Title X is an important source of preventive health care for women of childbearing age, and has become the largest provider of health services to adolescents. This is often an adolescent's first entry point into the health care system and with limited subsidized health services available for teenagers, it is a critical health program. In addition to family planning services, women using Title X programs receive a wide range of health screening procedures: pelvic examinations, breast examinations, cancer screening and VD testing among others.

Title X not only provides money for family planning services; it also supports education and information programs. At least two Child Welfare League agencies have received Title X money to develop education programs in their local communities. Human Services, Inc. in Denver, Colorado received Title X money to develop a program to involve males in the family planning process by using a nonmedical approach. The program has now evolved into a service which reaches all adolescents with information on teenage sexuality, responsibile relationship training and family life education. An important focus of the program is community workshops for parents to provide them with information and confidence to be the primary sex educators for their children.

Family Services of Charlottesville, Virginia, another CWLA agency, received Title X money to support a full-time Family Planning Community Educator who works with parents and youth on issues of birth control, decision-making, and responsibility. The educator spends time providing information to young people as well as working with parents to increase the comfort and ability to discuss family planning issues with their children.

The Title X program deserves the continued support of Congress. The continuing resolution funds Title X at $166 million. We recommend that this level of funding be maintained for 1981 and that the Title X program receive an appropriation of $190 million for FY '82. This increase is certainly justified by the cost-saving this program realizes as well as its success as a preventive health program.

Consolidation of Title X into a block grant will jeopardize 10 years of effective efforts toward reducing unwanted births. Consolidation would remove the guarantee of continuity of family planning services. Private agencies which are now receiving Title X monies would have to convince public agencies that they should continue providing the services and additionally would have to compete with other preventive health programs for reduced funds.

We recommend that the integrity of Title X be maintained as a separate categorical program.

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[1] Moore, Kristin A., et al, Teenage Motherhood: Social and Economic Consequences, The Urban Institute, Washington, D.C., January 1979. p. 6.

[2] op.cit., pp. 6-7.

Joint Statement of Mary S. Albert, Coordinator of Intergovernmental Relations, Georgetown University Medical Center; and T. Byron Collins, S.J., Special Assistant to the President for Federal Relations

We appreciate this opportunity to bring to your attention the urgent need to oppose certain proposed recissions and deferrals relating to health manpower for FY 1981 and the proposed budget for FY 1982. While we acknowledge and agree with the necessity for curtailed Federal spending, there are three programs which we feel should be salvaged.

National Health Service Corps Scholarships (NHSC)

Until some other mechanism providing for health professional services in shortage areas is put in place (e.g. a less costly service-contingent loan program such as was proposed by the Senate Health Subcommittee last Congress), all new NHSC scholarships should not be eliminated in FY 1981 and 1982. Many of our medical students at Georgetown (a total of 142) are presently in the program and we believe they are exemplary of a real commitment to service where they are most needed. The location of more physicians in shortage areas responding to competitive features to be introduced into the health care system will be some years in coming. It is important not to lose a continuing cadre of trained health professions to provide service in the interim.

Health Education Assistant Loan (HEAL) Program

The Health Education Assistance Loan (HEAL) Program is a guaranteed loan program in which medical, osteopathic and dental students pay the full cost of their loans (91 day T bill plus 3.5%) to pay for their educational costs. The proposed Reagan budget seeks to limit the credit obligation of the program to $100 million (presently, the continuing resolution authorizes up to $520 million). We urge that the loan limit of $100 million not be imposed. The borrowers in this program are low-risk; they pay the full costs of their loan. The program offers these students a last resort loan of no cost to the Federal budget. It is essential to keep this program intact as major economics are placed on student loan programs which do have considerable Federal budget cost.

Nurse Training

The national shortage of nurses is well-known. It is therefore particularly important that certain nurse training provisions not be cut as radically as proposed by President Reagan. Specifically, we urge restoration of funds for advanced nurse training, traineeships for advanced training and nursing loan programs. It is imperative that the leadership cadre in nursing be developed in order to help resolve the severe shortage of nurses which is expected to continue for some time. Without Federal support for several more years, many of these programs would founder, and nursing will suffer.

There are, of course, many other appropriations for health manpower support which we would support. However, these three items, which address particular health manpower programs, we believe deserve special support.

We appreciate this opportunity to present these views and request that they be incorporated into the record. On behalf of our President (Timothy S. Healy, S.J.) and Chancellor (Matthew F. McNulty, Jr., Sc.D.), we thank you.

STATEMENT OF DEAN BURK, PRESIDENT, DEAN BURK FOUNDATION

My name is Dean Burk. I have been a research biochemist with the Federal Government for 47 years (1929-1976), including 35 years in the U.S. National Cancer Institute (1939-1974), as briefly indicated in my Curriculum Vitae attached at the end of this testimony. I wish to speak to you on the medical and financial inadvisability of adding fluorides to public drinking waters.

As indicated in Item 1 attached, I estimate that there now some 40,000 cancer deaths a year in the United States that are linked with and induced by the fluoridated drinking water that 40% of the American population is forced to drink whether it wants to or not. At the widely accepted figure of about $25,000 total cost per cancer patient death, this amounts to a direct national loss of the order of a billion dollars a year.

Forty thousand fluoridation-linked cancer deaths a year represent one-tenth of the total annual cancer mortality in the United States. In terms of deaths and dollars, this tragic end result of enforced fluoridation astronomically outweighs any dental benefits from fluoridation that have been claimed but seldom adequately documented. In addition to cancer, there are a large number of other medical disabilities induced by fluoridation that have been reported in detail from all over the world, and summarized in many reviews and books, such as the recent book by Dr. George L. Waldbott, M.D., et al on "Fluoridation, the Great Dilemma," 1978, 423 pp.; Cancer Control Journal, Vol. V, No. 1 and 2, 1979, 180 pp.; and in the 1977 Hearings (560 pp.) of the House of Representative Subcommittee on Government Operations (Chairman, Hon. L. H. Fountain).

I have conducted fluoridation research personally in Australia, Canada, England, Scotland, Norway, Sweden, Holland, and South Africa, in all of which countries I have been invited to consult and lecture on this subject.

Attachment 2 shows graphically the abrupt and steep rise in cancer death rate induced in Birmingham, England after only a few years of artificial fluoridation of its water supply up to 1 part per million of fluoride, just as was found in the 10 largest cities in the United States, as evident in Attachment 1. The time course of cancer development here parallels closely the time course of development of cancers following the Japanese atomic bombing near the end of World War II, as reported in publications by the U.S. National Academy of Sciences and elsewhere.

All our fluoridation investigations to date have been brought to the attention of the British DHSS (Department of Health and Social Security, London), at its request, following an earlier conference held in September, 1979 attended by Health Minister Vaughan and his aides, along with Lord Douglas of Barloch (Deputy Speaker of the House of Lords), Hon. Ivan Lawrence (Chairman, Select Committee on Fluoridation, House of Commons), Sir Emmanual Kaye, Prof. Hugh Sinclair of Oxford University, and myself. Attachment 4 is a report in the London Daily Express of last October 12 in which Health Minister Gerard Vaughan announced instigation of an investigation into the safety of public water fluoridation. The concluding sentence of the article reports on the divided opinion among the medical profession as to the extent of prevention of tooth decay by fluoridation.

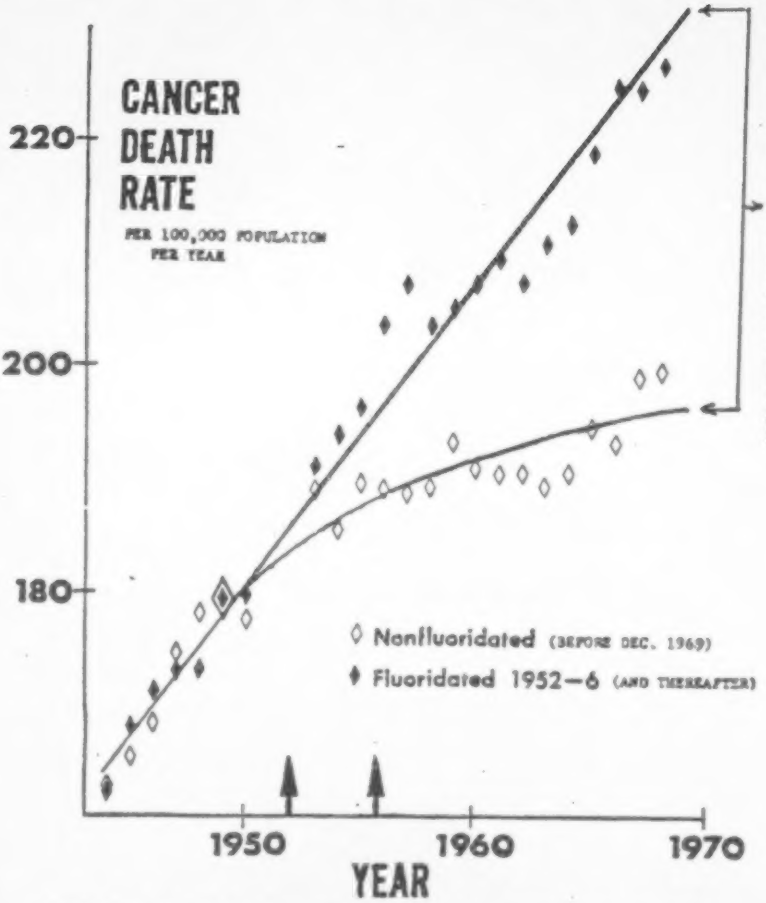
Attachment 3 is an abstract of a paper I offered at the 4th International Symposium on the Prevention and Detection of Cancer held in London-Wembley July 26-31, 1980. As Sir Emmanuel Kaye wrote to Prime Minister Thatcher on August 8, 1979, "None of our Common Market partners has fluoridated water. Thus, there is no fluoridation in Belgium, Denmark, France, Germany, Holland, Italy or Luxembourg. There is also no fluoridation in Austria, Greece, Norway, Spain or Sweden. Of these countries, Belgium, Holland, Germany and Sweden have all had some fluoridation and have stopped it. I am sure you will agree that the authorities of these twelve countries who have no fluoridation cannot all be fools." Attachment 4 is an update to April 1981.

On April 14, 1980, an Illinois court has begun hearings and trial with reference to elimination of public water fluoridation in the State of Illinois, following upon a similar suit in Pittsburgh in 1978 in the trial judge (Justice J. J. Flaherty finally ordered a halt to fluoridation in the area of Pittsburgh environs.

The Province of Quebec, after extensive investigations over a period of years, instituted a moratorium on any further public water fluoridation in that Province, and has recently curtailed or eliminated any provincial funds for a small pre-existing fluoridation involving 13% of the provincial population, and as of February 1980 has prepared a 208-paged report setting forth the scientific and medical basis for this decision.

Four years ago (1976) the Dutch Government by Royal Decree, following Parlimentary consideration, banning all public water fluoridation in Holland, after a detailed study of Attachment Item 1 and the extensive evidence supporting it.

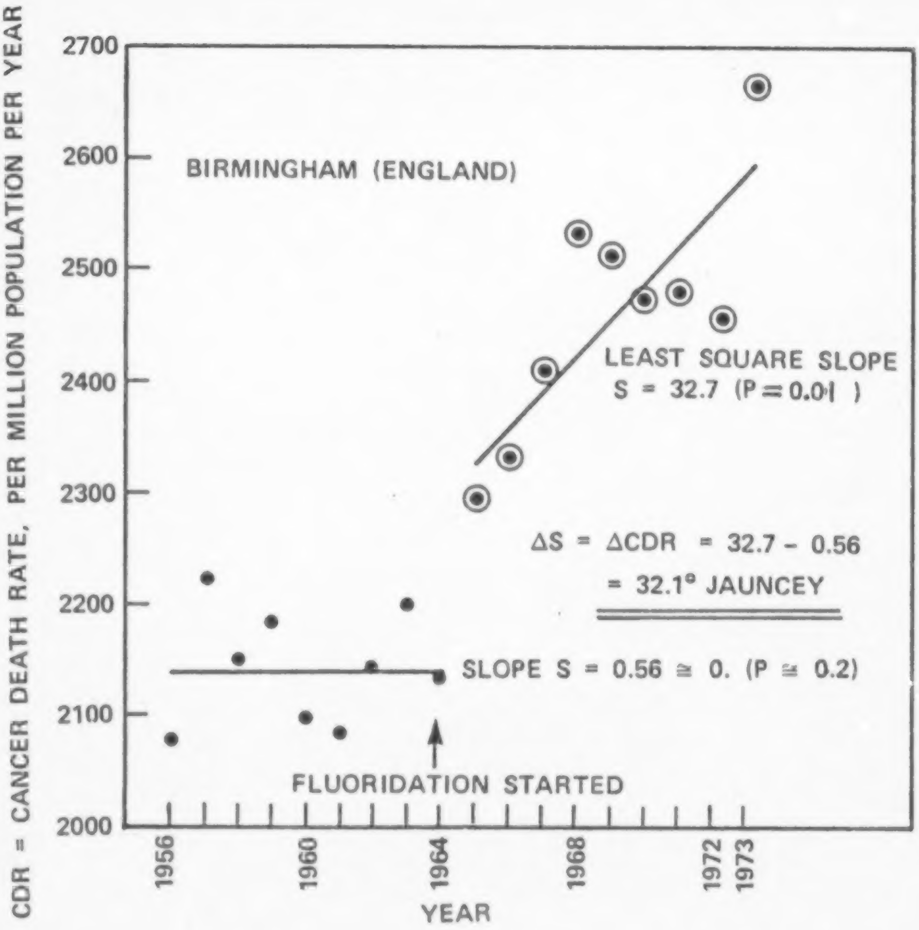
ATTACHMENT 1



1969 DIFFERENCE (EXCESS DEATH RATE IN ARTIFICIALLY FLUORIDATED CITIES) = 36 DEATHS/YEAR/100,000 PERSONS = 3600 DEATHS/YEAR/10,000,000 PERSONS (EQUIVALENT TO 29,000 DEATHS/YEAR/80,000,000 PERSONS SUBJECTED TO IMPOSED PUBLIC WATER FLUORIDATION.

COMPARISON OF THE 10 LARGEST AMERICAN CITIES FLUORIDATED SINCE 1952-1956: CHICAGO (1956), PHILADELPHIA (1954), BALTIMORE (1952), CLEVELAND (1956), WASHINGTON (1952), ST. LOUIS (1955), SAN FRANCISCO (1952), MILWAUKEE (1953), PITTSBURGH (1952), AND BUFFALO (1955)....... WITH 10 LARGEST AMERICAN CITIES WITH COMPARABLE CANCER DEATH RATES DURING THE PREFLUORIDATION TIME PERIOD, 1944-1950, BUT NOT FLUORIDATED AS OF 1969: LOS ANGELES, BOSTON, NEW ORLEANS, SEATTLE, CINCINNATI, ATLANTA, KANSES CITY (Mo.), COLUMBUS, NEWARK (N.J.), AND PORTLAND (Ore.). TOTAL RESPECTIVE POPULATIONS OF THE TWO GROUPS: 11,500,000 AND 7,000,000 PERSONS. DEATH RATES ARE PER 100,000 PER YEAR (NO DEATH RATES AVAILABLE FOR 1951-1952), TAKEN FROM "VITAL STATISTICS OF THE UNITED STATES" PUBLISHED ANNUALLY BY THE NATIONAL CENTER FOR HEALTH STATISTICS, US CENSUS ARROWS INDICATE THE YEARS OF FLUORIDATION INITIATION IN THE UPPER GROUP. SUGGESTED LINES DRAWN THROUGH THE DATA POINTS BY Dr. W. EDWARDS DEMING, CONSULTANT IN STATISTICAL SURVEYS. ALL CITIES ARE "CENTRAL CITIES". (December 1975)

Attachment 2



ATTACHMENT 3

ABSTRACT FORM

The Fourth International Symposium on the
PREVENTION AND DETECTION OF CANCER
London, July 26-31, 1980

Do not fold across abstract form. Fold this page only on dotted line.
Use an envelope for mailing that is larger than the abstract form to avoid folding.

fold *You may fold this page only on the dotted line, below.* *fold*

CANCER MORTALITY LINKED WITH ARTIFICIAL FLUORIDATION IN BIRMINGHAM, ENGLAND. Burk, D. Dean Burk Foundation, 4719 44th St., Washington, D.C. 20016, U.S.A.

Upon fluoridation of the Birmingham County Borough (CB) public water supply in October 1964, its ~1.1 million population showed one of the highest documented, abrupt, increases in cancer death rate (Δ CDR) of any large city in the world, far greater than occurred in e.g., the ~600,000 population of nonfluoridated Manchester CB or the ~300,000 population of only-15-miles-away Coventry CB, over the 10-year epoch of 1964-1973 after fluoridation compared to the 10-year epoch 1955-1964 before fluoridation. The Δ CDRs, based on linear least square regression slopes (CDR x time), for the respective three cities and two epochs, were: 38.4 - 4.9 = 33.5, 40.7 - 37.0 = 3.7, and 37.0 - 31.9 = 5.1 CD/million population/year, corresponding to a differential CDR increase in Birmingham CB, compared to Manchester CB or Coventry CB, of 30 CD/million population/year, or an annual increase of about 1.2% of the mean, annual, 1964-1973, Birmingham CDR (~2500), which is larger than the ~ 0.25%/year average, standardized differential for the 10 largest fluoridated cities in the US compared to 10 large nonfluoridated cities (Yiamouyiannis and Burk, Fluoride, 10, 102-123, 1977) /FLUORIDATION/CANCER MORTALITY/ BIRMINGHAM CB)/

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Abstracts will not be considered unless accompanied by the registration fee and form. Cheques must be made payable to: 4th ISPDC. All cheques originating outside the United States should be made payable in U.S. Dollars drawn on a correspondent U.S. Bank.

I wish to present a paper for: ☒ Podium Session ☐ Poster ☐ Exhibit ☐ Film

Postal address of author for correspondence:
4719 44th Street, Washington, D.C. 20016, U.S.A.
(After July 1, 1980, 23 Willow Road, Hampstead, London NW3, England)

The deadline for submission of abstracts is: January 31, 1980.
Abstracts MUST be typewritten in accordance with the instructions.

Signature ____________ Date January 29, 1980
(revised from Dec. 31, 1979.)

Thank you!

For: Oral delivery at annual meeting of the American Association for Cancer Research; Apr. 27-30 1981, Washington DC

AACR

1981 AACR ABSTRACT FORM

ABSTRACTS MUST BE RECEIVED
BY DECEMBER 8, 1980.

For Office Use Only

ATTACHMENT 4.

№ 5913

Perm. Abs. # ______ Temp. Abs. # ______

DO NOT FOLD

Type abstract in blue space below. See sample abstract on reverse side.

The original typed copy of this ABSTRACT FORM (for photoreproduction in the Proceedings) must be submitted along with 18 photocopies, the acknowledgment and scheduling cards, and two self-addressed, stamped envelopes. Questions regarding preparation of this FORM should be directed to the Cancer Research Editorial Office, telephone: 215-221-4720.

CANCER DEATH RATE (CDR) TIME-LINKED WITH FLUORIDATION OF DRINKING WATER IN BRITAIN AND U.S.A. Dean Burk, Dean Burk Foundation, Inc., 4719 44th St., Washington, D.C. 20016.

Fluoridated Birmingham, England, and the 10 largest fluoridated cities in the U.S., have been found to have shown immediate and sustained increases in cancer mortality upon fluoridation of their drinking water supplies with 1 p.p.m. industrially produced fluoride, when compared with 10 large nonfluoridated British cities (cf. Burk, 4th Int. Symp. on Cancer Detection and Prevention, London-Wembley, 3, 29-007, 1980) and 10 large nonfluoridated American cities (Yiamouyiannis and Burk, Fluoride, 10, 102-123, 1977). The fluoridation-linked cancer death rate increases (ΔCDRs) were clearly evident within five years, similar to the short latent periods for cancer induction found after the 1945 atomic bomb explosions in Japan (Beebe et al, Radiation Res., 75, 138-201, 1978). ΔCDR values were measured in terms of differential slopes of observed CDR as a function of time, before and after initiation of fluoridation, obtained by the method of least squares. Birmingham, fluoridated in late 1964, and with the most abrupt angular change in slope of any city studied, gave 59 excess cancer deaths/million population/year, for the epochs 1959-1964 vs. 1965-1970, but 30, 35, 36, and 51 less for Liverpool, Bristol, Manchester, and Sheffield, resp. (calculated from data of Cook-Mozafarri, and Doll, Production 12, Court of Session, Edinburgh, Sept. 1980). For the epoch 1953-1968, the 10 fluoridated American cities averaged 16 more than for the 10 nonfluoridated American cities. General conclusion: Fluoridated drinking water is unsafe for public consumption.

ALL QUESTIONS BELOW MUST BE ANSWERED BEFORE THE ABSTRACT CAN BE CONSIDERED BY THE PROGRAM COMMITTEE.

Session in which paper might be scheduled (check one only):

- ☐ Biochemistry and Endocrinology
- ☐ Biology and Genetics
- ☒ Carcinogenesis
- ☐ Clinical Investigations
- ☐ Experimental Chemotherapy
- ☐ Immunology
- ☐ Virology

Presentation preference (check one only); because of the size and complexity of the Program, final decisions must be at the discretion of the Program Committee.

- ☐ Poster
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FROM MARQUIS WHO'S WHO IN AMERICA

Vol. 38, 1974-75

AND

MARQUIS WHO'S WHO IN THE WORLD

Vol. II (1974-75)

Burk, Dean, biochemist; b. Oakland, Calif., Mar. 21, 1904; s. Frederic and Caroline (Frear) B.; B.S. U. of Calif., 1923, Ph.D., 1927; fellow Nat. Research Council and Internat. Edn. Bd., 1927-29 at U. of London (Univ. Coll.), Kaiser Wilhelm Inst. for Biology, Harvard; married Mildred Chaundy, January 28, 1929; children — Diana (Mrs. Richard A. Barker), Wendy (Mrs. Charles Maiorana), Frederic Chaundy; Asso. Phys. Chemist Fixed Nitrogen Research Lab., Dept. Agr., Wash., 1929, chemist, 1937-39; sr. chemist Nat. Cancer Inst., Nat. Insts. Health, Bethesda, 1939-48, prin. chemist, 1948-51, head chemist 1951-58, chief chemist 1958-74; asso. prof. biochemist Cornell U. Med. Coll., 1939-41; research master grad. faculty George Washington U., since 1947. Guest research worker U.S.S.R. Acad. Scis. (Biochem Inst.), Moscow, 1935. Mem. bd of dirs. Science Resources Foundation; Recipient of Domagk prize for cancer research, 1965: decorated Knight comdr. Med. Order Bethlehem; Fellow A.A.A.S. (organizer, chmn. research confs. on cancer, 1942-45); Mem. Am. Chem. Soc. (Hillebrand Award, 1952), Am. Soc. Biol. Chemists, Am. Assn. Cancer Research, Am. Soc. Plant Physiologists, Soc. Exptl. Biology and Med., (Chmn. 1949-50, sec.-treas. 1948-49), Am. Inst. Biol. Scis., N.Y., Washington Acad. Sci., Soc. Gen. Physiology, L.I. Biol. Assn., Harvey Soc, Chem Soc. Washington, Max Planck Assn. Goettingen, Inst. for Cell Physiology, Berlin. Royal Society Medicine, London; National Trust, Gt. Britain; Dolmetsch Found. Haslemere (foreign); Gamma Alpha, Sigma Xi; Clubs, Cosmos Club Wash. and Commonwealth Club of California; Author: Cancer, 1945; Approaches to Tumor Chemotherapy, 1947; Cell Chemistry, 1953. asso. editor: Record Chem. Progress, 1943; Proceedings Soc. Exptl. Biol. and Med., 1948-53, Enzymologia since 1937. Contbr. 250 sci. articles, Home: 4719 - 44 St. N.W. Washington, D.C. 20016.

Appointments and Awards, 1973-1974

1. Foreign Scientific Member, Max Planck — Institute of Biochemistry, Munich, Germany.
2. Honorary President, German Society of Medical Tumortherapy, Heidelberg, Germany.
3. Editorial Board, Krebsgeschen, Heidelberg, Germany.
4. Editorial Board, Cancer Biochemistry and Biophysics, Brunswick, N.J.
5. Cancer Control Society Humanitarian Award, Los Angeles.
6. Wisdom Society Award of Honor, Los Angeles.
7. Knight of Mark Twain Society (Succession to Sir Alexander Fleming), Missouri.
8. Distinguished Service Award in Biochemistry, Dictionary of Interntaional Biography, England.
9. Humanitarian Award, International Association of Cancer Victims and Friends, Los Angeles.
10. Guest Scientist, U.S. Naval Medical Research Center, Bethesda, Maryland 20014, 1974-1976.

THE DEAN BURK FOUNDATION

The Dean Burk Foundation, Inc., with headquarters at 4719 - 44th Street N.W., Washington, D.C. 20016 (Tel. 202-363-6279) was incorporated in the District of Columbia on November 18, 1974 as a non-profit corporation and non-private (public) foundation, and will be devoted to research on health, nutrition, chronic and degenerative diseases including cancer, will publish reports on same, will assist other groups and individuals with common goals, and will provide related educational material. The Foundation is exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code.

Statement of Candlelighters

Candlelighters, an international volunteer coalition of families of children affected by cancer, urges the committee to continue support for cancer research and programs for detection, treatment and rehabilitation, which extend and preserve the lives of the 6100 American children affected yearly by cancer. Although only one percent of cancer patients are children, except for accidents, cancer is the leading killer of children.

CLINICAL COOPERATIVE PROGRAMS: The dramatic gains in five year life expectancy for children with cancer in the past decade has gone from almost ten-twenty percent for those treated aggressively in centers of excellence, adequately staffed and equipped to sixty-sixty-five percent today. However, the national overall survival rate for childhood cancer victims is only thirty-nine percent.

Although the study of child cancer has pointed the way to advances in adult treatment, proposals call for cutting such research twenty-thirty percent, even while new innovative adult programs are being extended. The National Cancer Institute has brought quality care to local community hospitals, but it is acknowledged that these hospitals are not equal in treatment of pediatric cancers. Our children's hopes for cure rest with the center related clinical cooperative programs.

Cuts in Long-Term Effects Studies will limit efforts to refine treatment to avoid long term damage and potential secondary cancers and such cuts will stop the search for ways to reduce toxic treatments without jeopardizing cures.

An addition of $1,000,000 to Children's Clinical Cooperative Porgrams will permit the continuance of such research programs.

DIVISION OF CANCER CONTROL AND REHABILITATION: Rather than having the data merely shelved, studies which proved the success of home care programs for the terminal child in terms of both psycho-social and cost reducing potential need to be followed by studies directed to adolescent patients and by demonstrations of ways to implement them in the community.

NUTRITION: The excellent work resulting from the 1974 Diet and Nutrition Program needs to be continued. Funding must continue efforts to counteract the bombardment of pseudo-scientific and popular press claims for cure and control by diet, vitamins, Laetrile, etc. We request $100,000 to Clinical Cancer Education Program and $50,000 to Nutrition Program for 1) development of a curriculum for physicians in the field and in training to deal with information and responses to questions on dietary treatment and 2) materials to be developed and disseminated through Office of Cancer Communication, Cancer Information Service on such alleged nutritional cures or controls.

OFFICE OF CANCER COMMUNICATION: An excellent job is done. We are concerned however that children have no lay representative on any scientific or policy advisory committee of the Institute.

RESEARCH MANPOWER DEVELOPMENT: Because of the length (up to eight years) and expense of training to become an independent investigator, the recruitment pool of such researchers grows smaller each year. Grants must be increased in order to attract and keep more personnel or research programs will gradually come to a halt.

Statement of Lupus Foundation of America, Inc.

Background: NIADDK and NIAID are the two institutes at N.I.H. that conduct the majority of research in Systemic Lupus Erythematosus. Major research projects in the fields of Arthritis and Immunology are vital to unraveling the mysteries surrounding not only this chronic life threatening disease, but also, will do much to enhance the overall knowledge of Arthritis and the myriad of immune related disorders -- two areas that have been grossly underfunded not only in humanitarian terms, but also, in pragmatic terms of economic loss to society.

Investigators are now hovering on the brink of significant breakthroughs in the field of Immunology. Their excitement and enthusiasm is felt not only throughout the scientific community, but the rippling effects are seen and felt on all levels as the media translates these potentials to the general public.

The Proposed Budget F.Y. 1982 will drastically curtail three major areas that are essential to not only those with S.L.E. but in a larger sense will deal a devastating blow to the continued advancement of the quality of life that investigators have done so much to improve over the last decade: 1) training and research career development, 2) research centers, 3) intramural research Cutbacks in training and career development programs are of grave concern as the effects will not only be felt in 1982, but the backlash will cripple the biomedical research community for years to come. The cutback in funding for research centers closes important doors that N.I.H. and the government have in assuring the public their tax dollars supporting biomedical research translates into benefits with which they can readily identify. Furthermore, and of tremendous significance is that without clinical research programs laboratory investigation will not have the feedback it needs as to its effectiveness and benefits to society. The lack of adequate funding for intramural research is not only unexplainable as N.I.H. represents the premier biomedical research center in the country with resident scientists and achievements which are the vanguards of our health research efforts, but is also unexplainable as Congress looks for cost effect methods that are in the best interest of sound biomedical research policy. S.L.E. research potentially spans the spectrum of N.I.H. institutes, thereby exemplifying the need for integrated planning and inter-institute coordination of expanded intramural programs.

Recommendations:

1. The Professional Judgment Budgets submitted by NIADDK and NIAID be accepted.
2. Congress should allocate additional adequate funding to ensure that training and career development programs at NIADDK and NIAID are a top priority.
3. Congress should strongly encourage with sufficient increased funding the continuation and expansion of research centers supported by NIADDK and NIAID.
4. Congress should allocate additional funds to generate the expansion of integrated planning and inter-institute coordination of intramural research programs.

Statement of Dr. Lorin E. Kerr, Director, Occupational Health, United Mine Workers of America

Congress declared that the purpose of the Occupational Safety and Health Act of 1970 was "to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources". Congress also stated in the Mine Safety and Health Act of 1977 "that the first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource--the miner".

In 1980, despite the best intentions of coal mine operators and MSHA, 129 coal miners were killed on the job. There were another 18,000 whose injuries forced them to miss work. This lost time deprived families of customary income, denied the industry the full productivity of skilled workers and left miners suffering untold agonies.

These injury figures do not include the death of more than 4,000 coal miners each year that can be safely atributed to black lung. Nor does it include the 15 percent of the working miners with chest X-rays showing evidence of coal workers' pneumoconiosis.

If coal mine operators and MSHA permitted mine machinery to be destroyed or knocked out of commission at the same rate that miners are destroyed or knocked out of commission, we would have to agree that they were demented. But when carnage occurs in the workplace due to occupational disease and accidents, there is a tendency to speak about productivity problems that barely relate to those whose absence is the real source of these problems.

More than 14,000 workers die from accidents at work each year. Some believe that about 300,000 more workers die each year from job-related diseases. The Council on Environmental Quality projects that job-related cancers alone account for an excess of 20 percent of all cancer deaths. Some estimates run much higher.

In 1970 and again in 1977, Congress mandated that the National Institute for Occupational Safety and Health (NIOSH) is responsible for determining the cause of diseases and accidents in the workplace and conducting research designed to prevent death and disability. Many of NIOSH's recent accomplishments have been invaluable. Its assessment of the need to reduce the current exposure standards of uranium miners to radon-daughters has the potential of saving the lives of many uranium miners and millers now dying of lung cancer at a rate two to four times that of the general population. NIOSH's widely-acclaimed discovery of the high prevalence of silicosis at two silica flour mine and mill sites in Illinois has wide significance and application to all workers who are exposed to silica. At one worksite, the study reported a 39 percent prevalence of silicosis after one year on the job, and at another site a 27 percent prevalence after one year. NIOSH's expeditious testing of self-contained oxygen-generating respirators over the past three years is a matter of great satisfaction to miners throughout the country. Had these self-rescuer units been available 50 years ago, thousands of miners who were killed in explosions and mine fires might still be alive today.

The need for NIOSH has been recognized for years. But I am continually amazed and disheartened whenever I review NIOSH's proposed budget. I am also dismayed at the low status the Institute is accorded within the Department of Health and Human Services. The proposed budget of $55.9 million for FY 82 is a pittance given NIOSH's mandate and NIOSH's potential to save the lives of America's workers.

A modest budget of $200 million and 2300 positions would enable the Administration to provide the nation with a major preventive health program. Although the United Mine Workers of America promotes the expanded direct use of coal, we recognize that there are also promising new energy technologies which may play an important part in meeting

America's energy needs. New energy technologies contain a potential Pandora's box of toxic substances. It would be unconscionable to allow exposed workers to become sacrificial fodder, destroyed by new, as yet unknown, occupational diseases. The process of coal liquefication, the process of coal gasification, [illegible] essing of oil shale all contain potentially hazardous, toxic, and biologically [illegible] stances.

Limited information exists on the effects of occupational exposure to coal liquefaction on materials, but we do know enough to be worried. We need to prevent liquefaction workers from running an increased risk for developing cancer and respiratory illness.

It is imperative while synfuel technology is in the pilot stage that we develop the necessary control technology to prevent unnecessary occupational injuries and diseases. Besides guarding the welfare of synfuel workers, the early development of proper control technology may also minimize the need for costly retrofit controls at some later time. Protecting workers by controlling harmful emissions at the source may also solve potential environmental problems. NIOSH is proposing new projects for FY 82, such as examining the transfer of control technologies from analogous industries.

In America's drive toward energy independence, the synfuel industry is targeted for full development by the year 1992. Are we going to provide a safe and healthy workplace for today's seven-year-old who will start work eleven years from now? If NIOSH is to conduct an energy research program, it should have a budget of $25 million, with an allocation of 40 to 50 positions. The Department of Defense views oil shale as the liquid fuel most compatible with existing systems. We can expect a large investment of public funds into oil shale development. If we are to protect oil shale workers, we need to assess the basic health data. There is also a need to examine and evaluate the control technology presently being used in some of the pilot facilities. We know a lot about the basic chemicals derived from synfuels processes, but we don't know much at all about what happens when these chemicals are used in mixtures during the processing of raw materials. Research needs to be conducted here as well. There are still other emerging alternate sources of energy which are in dire need of occupational health and safety assessments. These range from tar sands and bio-mass synfuels, to enhanced oil and enchanced gas recovery, resource recovery from waste, and geo-thermal and solar energy. There are all sorts of exotic chemicals used in the manufacture of solar components.

The United Mine Workers of America promotes the safe and healthful use of coal. But there is a need to go back and look at the basic process of coal combustion, including what happens when oil facilities are converted to coal. There have been no industry-wide studies of coal-fired power plants. Are there potential problems which may have been overlooked? If there are, we want to see the control technology developed so our coal can be burned with maximum safety to power plant workers. No one yet knows the potential problems and hazards from using coal-oil mixtures, but this technology also has potential for expansion and needs to be assessed for occupational hazards. NIOSH is starting to compile an epidemiology registry of synfuel workers in conjunction with the Oak Ridge National Laboratory. Studies are being conducted on diesel exhausts toxicology, hydrogen, and alcohols, including the new process of coal into methanol. We want them to continue.

The position of the United Mine Workers on nuclear energy is well known. I have not come before you to debate its merits. But I feel obligated to indicate to you that there is a dire need for a commitment to conduct research to resolve the problems of low-level radiation. If nuclear fusion power develops, as some contend, research of the job-related injuries and diseases is a necessity.

The National Occupational Hazards Survey being conducted by NIOSH covering all industries is central to assessing the total magnitude of the nation's occupational health problems. Currently there is no accurate compilation of the results of dangerous exposure to toxic substances. The UMWA is gravely concerned that the National Occupational Hazard Survey for mining has been sharply curtailed due to budget cuts. We strenuously object to placing it on a backburner, thus reducing the survey to a pilot project. The National Occupational Hazards Survey should be alloted $4 million per year, with an additional travel ceiling of $2.5 million and 20 positions.

Health care providers, who are in an excellent position to observe abnormal symptoms in groups of workers, should also be plugged into the HHE program. Anytime cancer occurs in a work group, there should be a small study conducted. There could be two mutagens which are carcinogenic only when combined at a particular work-site.

A few years ago NIOSH conducted health hazard evaluations of the pesticide dibromo chloropropane (DBCP) when it was observed that groups of exposed male workers at the Occidental Chemical Company and the Shell Chemical Company had problems of infertility due to low or zero sperm counts. NIOSH's HHEs started a process which led to EPA severely restricting the wide use of DBCP. Residues of DBCP were also found in alarming concentrations in 19 common table vegetables and fruits. Many feel that the need to investigate and understand reproductive hazards will come to draw national attention similar to that given to cancer.

Until recently, research into reproductive hazards has been confined to women. Regrettably, this has often been used as a means to discriminate against women in industry. The effects of reproductive hazards on males have never been systematically investigated. There are many substances which have caused mutated sperm. There is also the problem of spontaneous abortions. Dirty workclothes have carried contaminants into the home. Children and fetuses are thus subject to unexpected exposures. But there is presently an inadequate data base to measure the magnitude of the problem of reproductive hazards. NIOSH needs to identify what causes reproductive hazards. There is a lack of efficient, inexpensive laboratory techniques to screen for reproductive effects-causing agents. NIOSH needs to develop these techniques. If NIOSH is to have a reproductive harzards program that will protect future generations of American workers, such a program should have a minimum of 42 positions and a budget of $5.2 million.

I have testified before this committee many times that the noise standard of 90 dBA is far too high and should be immediately lowered to 80 dBA. Now that personal noise dosimeters are beginning to be used in place of sound level meters in the coal industry, MSHA is finding that miners are actually exposed to far higher levels of noise than previous measurements had indicated. NIOSH needs to initiate a revitalized hearing conservation program for mining. There is also need to improve our ability to measure impact noise in mines. An adequate hearing conservation program for all industry needs an allocation of $7 million and 12 positions.

You are all familiar with the ravages of black lung. The total amount spent on federal black lung benefits to date now approaches $10 billion. Consider how much of this could have been avoided had sufficient money and effort been directed at an earlier date into the control of coal mine dust. It is questionable whether even now the effort presently being made is sufficient.

The mandated National Coal Workers Surveillance Program is not adequately funded. This program is designed to monitor the effectiveness of the $2mg/m^3$ respirable dust standard for underground coal miners. Participation in the X-ray program is down to 55%. An outlay of $18 million would assure participation of over 90% through NIOSH operating mobile X-ray equipment right at the mine portals, examining 25% of the miners each year during their shift. The government would eventually recoup its outlay because the law requires that coal mining operators pay for the X-rays.

When will America recognize the fiscal advantage of preventing occupational disease and disability? To date there is not even a commitment to develop something as simple and as basic as adequate protective clothing for every American worker. Decent and properly fitting hard hats, boots, gloves, coveralls, respirators, earplugs, and safety glasses are often not manufactured in womens' sizes. Even NIOSH women investigators run an extra risk when they conduct health hazard evaluations at a worksite. Many women have suffered sprained ankles because they wore three or four pairs of socks under poorfitting mens' hard-toe shoes and boots. Most women's hard-toe shoes and boots don't meet the American National Standard Institute's (ANSI) standard for men's safety toe footware. In fact, ANSI has yet to develop a standard for women's hard-toe footware.

The United States is the most industrialized nation on earth. Can you believe that in 1981 we do not yet have the means and the technology to provide every American worker with the fundamental type of protection which would be afforded by suitable and adequate protective equipment and clothing? Fifty positions with an annual budget of $10 million would start to provide both industry and workers with enormous potential benefits realized from a relatively modest appropriation.

NIOSH is currently developing a program that will include the promotion of proper use of personal protective equipment for people who work at hazard waste sites and for people who clean up spills of hazardous substances. The Environmental Protection Agency expects as reporting requirements are broadened that the number of spills of hazardous substances into navigable waterways will increase from 3,300 expected for 1980 to 9,000 spills per year by 1985. Recently there has been a rash of train wrecks and other transportation accidents which have created radiation and toxic chemical emergencies. The range of potential substances spilled requiring emergency responses to protect the public's health is nearly unlimited. Recent incidents have varied from the release of radiation tailings in Colorado, to pentachlorophenol in Kentucky, DDT in Alabama, asbestos tailings in Arizona, and trichloroethylene into drinking water in Pennsylvania. There are hazardous waste sites in nearly every state in the nation. How do you go about opening barrels of unknown substances, some of which contain flash points of 70 degrees, when opening the barrel generates temperatures in excess of 70 degrees?

NIOSH has a special responsibility to protect the safety and health of workers who clean up or are involved in emergency response to spills of hazardous substances. These workers are on the front line of protecting the health and safety of the public at large. It is tragic that time after time when emergencies occur, appropriate and sufficient protective equipment is not available. During the fire which occurred at a waste dump in Elizabeth, New Jersey, there was only enough personal protective equipment for one shift of workers. All three shifts and many fire departments were called out for this emergency and hundreds worked around the clock to protect the public.

Under a recent agreement with the Coast Guard, OSHA, and EPA, NIOSH was designated the lead agency to develop a comprehensive guidance manual designed to protect workers involved in hazardous waste site investigations and cleanup and in emergency response to spills of hazardous substances. Materials need to be developed that both promote the use of personal protective equipment and delineate the limitations of personal protective equipment with regard to site characteristics and the substances encountered.

NIOSH also needs to develop a program for new waste sites that include engineering controls designed to eliminate exposures and eliminate the need for workers to wear personal protective equipment. This program should have 9 positions with a budget of $5 million.

The field of occupation safety is now at the point of development where general medicine was 100 years ago. There are presently no more than twenty fully qualified university professors in the field of occupational safety with Ph.D.s. Our nation needs 100 such people. We're now making do mostly with engineers who have no formal training in occupational safety. NIOSH is in the quintessential position to develop curricula packages, given NIOSH's expertise and knowledge of the control of occupational health and safety problems. But for NIOSH to do this, it will take an initial outlay of $3 million and a continuing annual cost of $1 million.

There are no more than ten people nationwide with Ph.D.s in occupational nursing who are teaching that subject. We need from twenty to thirty such people. One mechanism by which we can attract people, dedicated to a career in occupational safety and health and build a national corps of top-grade faculty for our colleges and universities is through expanding NIOSH's dissertation grant. A dissertation grant funds a Ph.D. candidate for three years at a cost of approximately $15,000 per year. I know of no other way that we can develop the necessary professionals to properly staff faculties of occupational nursing and safety. But the costs of developing these specialties are miniscule when compared to the benefits American industry will reap. Eighty dissertation grants in occupational safety engineering and 20 dissertation grants in occupational nursing would require $15 million.

We also need to build an occupational safety and health reserach base in the academic community, if we are to fully tap out nation's intellectual resources in the service of American workers and American industry. To develop this, NIOSH's research grant program should be allocated $50 million per year, not dried up. The President has proposed an increase in the National Institutes of Health research grants program, which doesn't begin to approach the relevance of NIOSH's program in solving national problems.

With this presentation, I have endeavored to delinate the monumental task confronting NIOSH in its Congressionally-mandated endeavor to prevent job-related death and disability. This is truly the most serious health problem confronting the nation. While I have referred to only a few of the total costs and positions, please be assured that the proposed FY82 budget figures of $55.9 million is only fifty-six cents per annum for employed civilian workers. I strongly urge you to consider that authorization and appropriation of $200 million will commit the Administration to an essential preventive health program that will also assist immeasurably in the containment of rapidly rising medical care costs.

STATEMENT OF RELIGIOUS COALITION FOR ABORTION RIGHTS

The Religious Coalition for Abortion Rights is a coalition of 26 national Protestant, Jewish, Catholic and other religious groups whose denominational constituencies total approximately 27 million. These groups joined together originally in 1973 in an effort to maintain the option of safe and legal abortion for all women who chose it, consistent with sound medical practice and their moral and religious beliefs.

Since 1976, despite the fact that it is contrary to both House and Senate rules, appropriations bills have been used as vehicles to establish *de facto* a federal policy on abortion which we believe constitutes an infringement upon the rights of individuals - including the members of our denominations - to follow the teachings of their faith on matters related to their moral convictions about parenthood and the responsibilities related to it.

The Religious Coalition for Abortion Rights wishes to go on record once again in opposition to any restrictions proposed for inclusion in FY 1982 which would deny funding for medically necessary abortions. It is our conviction that poor women dependent on the Medicaid program for their medical care should receive the same level of conscientious and comprehensive health protection that is available to others in our society. We believe that the medical procedure of abortion must therefore be among the health services made available to all women, without regard to economic circumstances when that procedure is determined to be medically necessary.

What is at stake here is the health and well-being of poor women, for which our society has assumed a responsibility through the Medicaid program. We believe that excluding abortion from the services available through Medicaid violates the intent of the Medicaid statute, which seeks to make a full range of health, rehabilitation, and education services accessible to all our citizens regardless of their own ability to meet the costs of such programs, "to help such families and individuals attain or retain capability for independence or self-care." Without Medicaid assistance lower and marginal income Americans have no means of securing these important services. Thus an explicit prohibition of any particular service such as abortion effectively excludes the poor from necessary health care available to others with higher incomes, and promotes and perpetuates discrimination.

The stated goal of the legislation is significantly distorted by the abortion restrictions, since doctors treating poor women are forced to abide by a different (and less adequate) standard of care that they can provide for other women in society. Rather than allowing a medical doctor the latitude he/she needs to determine and provide treatment, doctors caring for poor women may not receive Medicaid reimbursement for performing abortions unless the woman's life is endangered by pregnancy or unless she is a victim of rape who reports the crime to a law enforcement or health agency within 72 hours, or a victim of incest. This limitation was adopted in the Continuing Appropriations resolution of 1980 after protracted debate and confrontation between the House and Senate.

The recent Administration proposal would restrict Medicaid abortions even further, by eliminating abortion services for all victims of rape and incest. Despite the fact that only 25 or 30 women who were victims of these crimes received federally funded abortions last year, the Administration claims that the current law provides "a giant loophole."

However, we believe that the cost, in terms of human suffering, of the President's proposal is insupportable. It does not allow for compassionate treatment of the poor woman who is under treatment for mental illness, whose only hope for recovery rests in the use of powerful drugs which have an adverse effect on the fetus. It provides no option to the woman who has six children already and simply cannot support another. It offers no humane alternative to parents who know from medical tests that the child they expect will be severely deformed at birth with little chance for survival. And it withdraws the means to secure adequate medical care from the woman whose own precarious health is even further jeopardized by an unplanned pregnancy and the 11 year old girl who is a child herself and who is impregnated by her father.

We have a deep concern for the women who are compelled to carry problem pregnancies to term, risking their health and in some cases their lives. We care also for those women who will be forced by their circumstances to resort to self-induced or back alley abortion. As religious organizations and individuals, we cannot agree with those who claim that "there are no situations where abortion is medically or psychologically justified."

On June 30, 1980, the Supreme Court addressed the issue of public funding for medically necessary abortions for poor women eligible for Medicaid. While the Court's 5-4 decision denied a constitutional mandate for the funding of such abortions, it affirmed the right of Congress to continue this necessary medical service and the responsibility of Congress to enact wise public policy on this difficult issue:

> "It is not the mission of this Court or any other to decide whether the balance of competing interests reflected in the Hyde Amendment is wise social policy. If that were our mission, not every Justice who has subscribed to the judgement of the Court today could have done so. But we cannot, in the name of the Constitution, overturn duly enacted statutes simply 'because they may be unwise, improvident, or out of harmony with a particular school of thought'..Rather, 'when an issue involves policy choices as sensitive as those implicated (here)...the appropriate forum for their resolution in a democracy is the legislature.'"
>
> Harris v. McRae

We believe that public policy on this sensitive issue should be debated in a broader context than that afforded in an appropriations bill. If, however, the Senate is to address the issue in this bill, by placing restrictions on health coverage, it should first thoroughly assess the costs of a restrictive policy such as the Hyde Amendment in both human and fiscal terms.

Studies conducted by the Center for Disease Control indicate that in the first year following the cut-off of federal funds in 1977, some Medicaid-eligible women managed to secure privately funded abortions. They did so, however, an average of 2½ weeks later in gestation than did women not eligible for Medicaid (although no such differential existed in states which continued to fund). Since each week of delay increases risk of complications by about 20% and risk of mortality by about 40%, it is clear that the Hyde Amendment imposes additional health risks upon women who, because of multiple factors related to poverty, already have a higher incidence of health problems than the average for the population as a whole.

The average cost of an abortion in the U.S. is $285. The average monthly welfare payment for a family is $241, or $44 less. Put another way, the average cost of an abortion is equal to the average welfare family's food allotment for three months. Thus, a woman seeking a medically necessary abortion may be faced with deciding between her own health and welfare - which ultimately affects the welfare of her young family - and the immediate needs of feeding and clothing her children. Or perhaps she has a third choice, that of obtaining money for an abortion by resorting to crime or prostitution.

The Center for Disease Control reports three deaths associated with the unavailability of funds during the first 18 months of the funding restrictions. Since that time, funding has been further limited. If this policy continues, we can expect that more women will die or suffer serious health damage as a result of complications of pregnancy or back alley abortions. A significant number of those affected will be young teens for whom pregnancy poses higher than average medical risks.

While our support for freedom of choice is not based on fiscal considerations, there is a considerable body of evidence that the cost of financing abortions for women who choose them is many times less than that associated with childbirth and subsequent services which must be made available to an indigent famliy.

The actual purpose and effect of the Hyde Amendment is merely to reduce the number of abortions available to poor women and to frustrate a woman making an abortion decision in consultation with her physician and for medical reasons. In fact, the impetus for the amendment itself stems from a religious bias against abortion that is not shared by all American citizens and not taught by all religious faiths.

Thus, in addition to our concern for the health and well-being of poor women and our commitment to the principle of equal access to quality health care for all, regardless of income level, RCAR has an even more basic and compelling reason for objecting to abortion restrictions in the Labor/HHS Appropriations bill. We believe that these restrictions deny religious liberty to poor women by preventing them from following their own conscience and religious convictions on abortion. Within the religious community, there are widely differing views on abortion. There are some religions that object to abortion under all circumstances. This view is based on the belief that a separate, equal human life exists from the moment of conception and that abortion represents murder. However, there are also faiths which teach that separate, equal human life begins sometime between viability and birth. While these religions have a deep respect for the human potential of a fetus, they do not consider it a full human person with rights equal to those of existing individuals. Therefore, many of these religions agree that when a problem pregnancy would result in tragic circumstances, abortion should be considered a moral alternative and one which may be the most loving and responsible solution.

The United Presbyterian Church, U.S.A. clearly teaches that "God has given persons the responsibility of caring for creation as well as the ability to share in it, and has shown his concern for the quality and value of human life." We recognize that there are times when "the natural ability to create life and the moral and spiritual ability to sustain it are not in harmony", and therefore moral and ethical decisions about abortion are incumbent upon individuals of faith (Resolution of the 184th General Assembly of the United Presbyterian Church, U.S.A., May, 1972 - reaffirmed 1980).

The United Methodist Church counsels that, "When, through contraceptive or human failure, an unacceptable pregnancy occurs, we believe that a profound regard for unborn human life must be weighed alongside an equally profound regard for fully formed personhood, particularly when the physical, mental and emotional health of the pregnant woman and her family show reason to be seriously threatened." (Resolution on Responsible Parenthood, reaffirmed in 1980 by the General Conference of the United Methodist Church).

In Judaism, a fetus is not considered a full human being and for this reason has no "juridical personality" of its own. According to Jewish law, the fetus in the womb is not a person (lav nefesh hu) until it is born (Rashi, Yad Ramah, and Me'iri, all to Sanhedrin 72b). According to Scripture, while the fetus clearly has value, its loss may be atoned for by monetary compensation, but there is no capital liability for foeticide as there is for the loss of human life. By this reckoning, abortion cannot be considered murder.

While Jewish law teaches a reverent and responsible attitude to the question of life and thus views abortion with great concern, reasons affecting basic life and health may sanction or even require therapeutic abortion. For example, Jews are particularly subject to Tay-Sachs disease - a genetic disease fatal to infants. No Tay-Sachs child has ever lived beyond five years of age, and each dies an agonizing death. Tay-Sachs disease cannot be detected until the second trimester, and thus no therapeutic action can be taken until that time. Were the beliefs of another religion concerning abortion to be enacted into law, the right of Jews to follow their convictions would be denied.

RCAR remains profoundly sensitive to those individuals who feel compelled, on the basis of religious beliefs, to reject abortion as an alternative to a problem pregnancy. However, because there is no agreement on this subject within the religious (or medical or legal) community, government policy on this matter must allow people of all faiths to practice freely their own belief.

Finally, we would stress that no member of RCAR advocates abortion or considers it an easy solution to a problem pregnancy. Certainly none consider it a desirable means of family planning. We are hopeful that in the future, the need for abortion will be reduced. Within the programs funded by the Labor/HHS Appropriations bill, there are a broad range of services for family planning and contraceptive research which we hope will increasingly meet the needs of the poor and alleviate the problems which lead women to seek abortions. We strongly believe, however, that complete abortion services, including referral and counselling, must be among the services available to the poor through these publicly funded programs. We would hope that the House and Senate will see fit to appropriate sums of money to insure the success of these programs.

For all of these reasons, we urge the committee to delete all abortion restrictions in the FY '82 Labor/HHS Appropriations bill, and to restore to lower income women their right to obtain safe abortion services.

Statement of Miss Nellie J. Gray, President, March for Life, Inc.

I am Nellie J. Gray, President of *MARCH FOR LIFE, Inc.* of Washington, D.C., a non-profit, non-partisan, and non-sectarian organization with the purpose of assuring that the value and dignity of each human being, born and preborn, shall be protected by the laws of our land.

I come to you today because of our long-standing and deep concern that there is a depreciation of this value and dignity of human beings, even supported by the action of our government through this Administration and this Congress, both of which have the power and authority to reaffirm the inalienable right to life of each human being and then to act to assure that this right is protected as the "paramount" right of each American.

The most prominent visibile sign of callous disregard for the right to life is by abortion in our land today. Thus, this testimony is directed to that issue, which is but the bloody tip of the mentality to reduce human beings to materialistic raw material.

RESOLVE THE ISSUE IN FAVOR OF LIFE, NOW -- NO OTHER WAY

Mr. Chairman, I regret very much that I have to come before the Congress again and ask that you stop the federal tax dollars from being used to kill innocent preborn children. Congress should have known that such payments should never have been made in the first instance. By now, I am sure, you are tired of this constant struggle with the life and death issue which continues before the Congress. I, too, am very tired and very, very impatient.

However, the abortion issue is not going away until it is resolved in favor of life, so remove abortion once and for all from any legitimate place in any part of the lives of Americans. By a combination of the official efforts of all branches of our government -- Judicial, Legislative and Executive -- an abortion massacre has been going on in America for 8 years -- that's 8 years too many. This Congress can and *must* stop abortions -- both the funding and the abortion acts. Now, get down to serious business of effectively carrying out your responsibilities as elected representatives of the American people, and stop the American holocaust!

HUMANITY OF THE PREBORN CHILD

Abortion remains a hot issue before this Congress because it involves the lives of human beings -- the humanity of the innocent preborn human being as a victim for death and the humanity of the family of that preborn human being -- the child's mother, father, grandparents, and society as a whole.

Abortionists and those skirting the issue of abortion want to erase the humanity of the preborn child and his family from the issue. But, it cannot be done.

THE HUMANITY OF THE PREBORN CHILD *(cont'd)*

Mr. Chairman, before this Committee can consider abortion any more, it must open its eyes, head, heart, and ears to the simple facts of the humanity of the preborn child.

I say it is simple—and I truly mean that.

A unique human being comes into existence when the father's sperm fertilizes the mother's ovum. The genetic code is set, and the preborn human being, in its natural habitat of the mother's womb, grows until birth, and then grows from infancy throughout a natural continuum of life. At no period of that life span is that human being more or less human than at the time of fertilization. Thus, that life and each human life must be protected from the moment of fertilization. [1]

It is because of this humanity of the preborn child, and the abortionists destruction of an innocent human being, that the abortion issue is a hot one. It falls into the category of repeated incidents in history which show, unrelentingly, the fact of man's inhumanity against man. Never were any of these periods in history peaceful periods, but are marked, starkly and unrelentingly, by turmoil as people of good will defended innocent victims who could not defend themselves. There was the period of slavery in our own history, and the period of Jews and the final solution in Germany.

Now, in our times—as if some people cannot learn from history—the killing of preborn children. You are witness to the unrest it causes in our land, and this unrest will continue until the killing stops.

CUT OFF ALL -- THAT MEANS ALL! -- PUBLIC FUNDS FOR ABORTION

Mr. Chairman, I appear before this Committee today to ask that you act in one area in which you can uniquely act. You can stop all—that means all—public funds being used for abortion.

Abortion—killing innocent preborn children—is big business in the United States, much of which is funded by public tax dollars. Abortionists have a special vested interest—a pecuniary interest—in keeping the tax dollars flowing into their pockets.

Mr. Chairman, and Members of this Committee, cut this blood money off! And now!

You do this by beginning with the right premise. Abortion kills preborn human beings; using tax dollars for this purpose gives official approval to this killing; therefore, no tax dollars shall be used for killing preborn children.

You began with the wrong premise in 1977, and you came out with the wrong legislation. Congress began with the equivalent of "No tax dollars shall be used to kill preborn children, *except that* tax dollars can be used to kill preborn children in certain circumstances."

Sad, Mr. Chairman, but, from the beginning of trying to stop tax funds being used for abortions in 1977, there was not the firm purpose to stop all funding. Therefore, it meant that Members of Congress over a six-month period were compromising, negotiating, and downright haggling, over: "Which preborn human beings shall be permitted to live and which shall be permitted to be killed by abortionists and paid for with tax dollars."

This Committee and this Congress can no longer take that position.

CONGRESS CANNOT COMPROMISE THE LIFE OF A PREBORN HUMAN BEING

There is an oft-repeated saying on Capitol Hill that legislation is arrived at through the art of "compromise." Compromise, by definition, means that each side gives up something in order to arrive at a settlement. But, when the subject is the life of a preborn child and part of the life span of many human beings, Congress cannot give up something without giving up life—and that life is not Congress' to give up.

All of the House-Senate compromises in Defense, D. C., and Labor/HHS Appropriations Act were based on the premise that there is something less human and less valuable about the preborn child and it may be disposed of at will. This type of thinking even brought to the floor of the House and the Senate the odious proposition that preborn children should be tested for defects and killed with tax dollars if found to be defective—whatever that meant and by whatever criteria individuals would unilaterally judge whether the child met the standards of being "perfect" for life.

It is imperative that Congress get these "exception clauses" for the "life of the mother" and all other exceptions out of your vocabulary and thinking, and begin to understand and work for the premise that "all reasonable efforts and ordinary means must be used to save either and/or both the mother and her preborn child or children because each of these born and preborn human beings have an equal value of life and an equal right to live and an equal right to be protected by the law of our land.

[1] See attached pamphlet: *SCIENTISTS FOR LIFE, INC., The Position of Modern Science on the Beginning of Human Life, 1975.*

THERE IS NO "NEED" TO KILL INNOCENT PREBORN CHILDREN! Pertinent to this point is a question which was asked of *MARCH FOR LIFE, Inc.* in 1978 by the Honorable Louis Stokes of the House Appropriations Committee. The question was:

> Do you support any exceptions at all for abortions? What about cases of women who are crippled, who have multiple schlerosis, diabetes, cancer, heart disease, mental illness, or other of many medical conditions where a doctor and the woman would find the pregnancy to be inadvisable -- medically?
>
> *(There was a three-page response to Mr. Stokes' question, which included the following statement by William J. Hogan, M.D., in private practice as Obstetrician/Gynecologist in Bethesda, Maryland.)*
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> * * * *
>
> *We do not support any exceptions at all for induced abortion, which is the direct killing of an unborn child. We believe, with Hippocrates, that a physician, operating in the best interest of both his patients -- mother and child -- can never directly intend to kill either of them.*
>
> *As early as 1951, at the Congress of the American College of Surgeons, Dr. R. J. Heffernan of Tufts University, stated: "Anyone who performs a therapeutic abortion for physical disease is either ignorant of modern*

methods of treating the complications of pregnancy or is unwilling to take the time to use them." {1} How dramatic has been the further advance of modern medicine since 1951 hardly needs comment. Open heart surgery and kidney transplant are just two striking examples of this dramatic progress in medicine. Numerous successful pregnancies have been reported following open heart surgery and kidney transplant, to name just two medical problems.

All the medical conditions you have mentioned in your question can be cared for skillfully in modern medicine, so that the life of the mother and the child are both sustained. The killing of the child within the womb of a woman with a serious medical condition, in itself, poses a risk to the life of the woman.

Before abortion became legalized in America, doctors did indeed apply their medical skills in preserving the life of both mother and child. Dr. Frederick L. Good, former Surgeon-in-Chief of Boston City Hospital, Obstetrical & Gynecological Service, reported in 1951, that no therapeutic abortions were performed in that hospital in a 30-year period, and that during that time, the mortality rate due to conditions supposedly benefitted by therapeutic abortions had been zero. {2} There have been many major university hospitals that have gone a decade or more without performing a single therapeutic abortion. For example, prior to 1968, the University Hospital of the College of Medicine, University of Cincinnati, did not perform a single therapeutic abortion in 15 years.

{1} Article in American Journal of OBGyn, Vol. 66, No. 2, Aug 1953, pp 335-345.

{2} Good, MARRIAGE, MORALS & MEDICAL ETHICS, New York, 1951, p. 148-49.

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THE OBJECT LESSON FROM CONGRESS' EXPERIENCE WITH STOPPING FUNDING OF ABORTIONS

In summary, Congress may draw some of the following guidelines for additional work to stop *all* public funding of abortions:

— Start from the right premise to get to the right outcome, namely, intend to stop *all* funds for abortion, mean that, and stick with it.

— Write legislation to save and care for human beings, namely, the defenseless preborn human being and preborn's mother and father. Do not write legislation for the abortionists or to appease the abortionists.

— Recognize that abortion is big business in killing human beings, much of which is paid for with tax dollars and tax exempt status. Congress doesn't even know how much public money is going into this business, and, therefore, cannot blindly appropriate funds to enrich a business. It would seem that the Congress would be particularly diligent in finding out the facts, because abortion is not a white collar enterprise but a bloody massacre equal to the "Holocaust."

— Recognize that there is no such thing as a "safe abortion." Every abortion kills at least a preborn human being, and subjects the mother of the preborn child to physical, mental, and emotional risks and damage.

— Write legislation to save both the mother and her preborn child, without exceptions.

— Don't compromise and then expect to "hold firm," because there is no position on which to hold firm. After compromising, it is impossible to draw a halt—the abortionists have already seen the weakness and will exploit it.

— Abortionists cannot be "appeased." Don't give them even one provision under which they can get public funds to kill preborn human beings. One exception leads to another, and another, and another, and another . . . .

— Recognize that abortion business deals not only with killing preborn children but also seeking them out for killing through prenatal diagnosis. Congress must provide funds to treat patients, *not kill* those found by a unilateral decision to be "defective."

— Congress and the Administration have approved abortion and are now deeply involved in the abortion business, thereby implicating our whole country. Congress and the Administration have the authority and power to stop the killing of preborn children. There will be an accounting of the activity of all public officials.

— History will record that some spoke up against the massacre of preborn children. There is a prolife movement across our country. Prolifers are tired of public officials not doing the job they are paid handsomely to do—to protect our people and our country. Prolifers are tired of using our time, energy, homes, families, and small financial resources from our own pockets to lobby Congress and the Administration to stop the killing in our country.

— Some things cannot be compromised: Human life is one. When you compromise any part of the life span, you participate in the killing of a human being.

— Don't permit the provision to stop public funding of abortions to be held hostage and defeated by diversionary tactics and emotional appeals such as: poor *vs.* rich, government workers' payless paydays, etc.

THE SUPREME COURT AND THE ISSUE OF PUBLIC FUNDING OF ABORTIONS

The Supreme Court's decision *Harris v. McRae* of June 30, 1980 underscores the position which *MARCH FOR LIFE* takes in this testimony. For instance, the Supreme Court agrees that the cutting off of public moneys for abortions bears a rational relationship to the Government's legitimate interest in protecting the fetus.

Further, the Court explicitly stated that the Congress is entrusted with the decision of allocating the funds among competing interests. *MARCH FOR LIFE* again repeats that killing innocent preborn children is not a legitimate interest on which public moneys shall be spent. The Court says that when an issue involves policy choices as sensitive as those implicated by abortion, the appropriate forum for their resolution in a democracy is the legislature.

The Court also recognizes that abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of the "potential" life. The Court could not bring itself to say that a human being is killed by abortion, but it came close.

This decision -- not a courageous or a great one -- merely states what has been the law and intent of the law for a long time in our country, and provides the firm legal base for this Congress to deny all public funds for abortions.

RECOMMENDATIONS FOR PROVISIONS OF APPROPRIATIONS BILLS PASSED BY CONGRESS

TO ASSURE THAT NO PUBLIC FUNDS SHALL BE USED FOR ABORTIONS

Begin with the firm attitude that *no* tax dollars shall be used for abortion, and clearly say so in the legislation. When getting to the "hard" issue of the "life of the mother exception," be sure that the premise for dealing with this issue is that *both* the mother and her preborn child shall be saved and neither one is to be killed to save the other. The following positive approach is proposed, which is based on the premise that tax dollars shall be used to truly "save" lives, even if, unfortunately, some lives cannot, with current medical science, be saved. The proposed text is:

> *Sec. ____. None of the funds appropriated under this Act shall be used to pay for abortions performed by any means during the prenatal period beginning when the sperm fertilizes the ovum; nor shall funds be used to promote or encourage abortions. When a true medical emergency exists with the physical conditions of a pregnancy and reasonable efforts and ordinary means are used in accordance with good medical practice to try to save the lives of the mother and her preborn child or children, funds appropriated hereunder may be used to reimburse for these necessary medical services, even though a life or lives cannot be saved.*

In order to clarify the intent of this section, it is recommended that the following language be included in the Committee's Report:

> *The purpose of Sec. ____ is clearly that no reimbusement for abortions shall be allowed, and no funds shall be spent for abortions in any manner or means. This includes payment for drugs and devices which are abortifacients and payments for the services of anyone who prescribes such drugs and devices. Such payments cannot be made directly or indirectly.*
>
> *This Committee recognizes that at this stage of medical science there may be rare instances when the lives of both the Mother and her preborn child or children may be physically endangered by the circumstances of a pregnancy. When a true medical emergency exists with the physical conditions of a pregnancy, this Committee expects that reasonable efforts and ordinary means, in accordance with good medical practice, shall be used to try to save the lives of all patients—the Mother and her preborn child or children. Federal funds appropriated hereunder may be used to reimburse for these medical services undertaken to save the lives of these patients, even though the life or lives of one or more of the patients may not be able to be saved.*
>
> *Payments cannot be made directly or indirectly to treat mental, emotional, pre-existing physical conditions, or physical conditions not associated with the pregnancy by performing or prescribing abortion.*
>
> *The Committee expects that under these and similar conditions, the lives of all patients will be saved and that funds shall be available for this life-saving treatment.*

AND SO, MR. CHARIMAN, WHAT TO DO?

MARCH FOR LIFE respectfully asks the Congress to carry out its legislative responsibility to enact a provision in this Appropriations bill which will give moneys to save both a mother and her preborn child, and to deny any public moneys for killing innocent preborn children.

So, Mr. Chairman, what to do? It is simple. As you manage this Appropriations Bill through the Congress, you stand on the Floor and say, for all the world to hear, that because the American people and their Government cannot be implicated in the killing of innocent preborn children, this Appropriations Bill has a section which provides unequivocally:

§ __________. *NO FUNDS FOR ABORTIONS.*

Mr. Chairman, I am not talking about getting the "best bill possible in a difficult conference situation;" I am talking about standing up for the right to life of each and every born and preborn human being, because it is right to do so.

What to do? Please shed the niceties of the legislative jargon on the Floor and in Committees and say that Congress will not continue to participate in even "A Little Bit of Abortion." Please also say that if this provision is not passed by Congress, you are prepared to dismantle all authorizing legislation which can conceivably be construed as permitting abortion. There is not time for trying to pacify the abortionists any longer.

The position I am suggesting for this Committee and the Congress is not one of being brave or courageous. There simply is no other tolerable position to take, unless Congress wants to continue to be implicated in the slaughter of millions of innocent preborn children.

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